Sleep Diary

Do you have Trouble Sleeping?

Do you awaken in the morning feeling tired or unrefreshed? Most sleep problems can be easily managed. A good place to start is to record your sleep habits and daytime alertness in a sleep diary. Completing this diary will help you identify patterns or conditions that might be affecting your sleep.

How to Use the Sleep Diary

The sleep diary takes only a few minutes each day to complete. Keep it in a convenient place, such as on your bedside table. Complete the diary for seven consecutive days, or copy it and use it for a longer period of time. Then, review the diary with your parents to see if there are any patterns or habits that may be contributing to your sleep problems. Take your sleep diary, and a list of any questions that you have to discuss with your

Sleep Diary

	COMPLETE IN MORNING							COMPLETE AT END OF DAY				
Fill out days 1-3 below and days ***4-7 on back***	**Bedtime**	**Waketime**	**Time to fall asleep**	**I woke up during the night:** *(# of times)*	**When I woke up, I felt:** *(Check one)*	**Last night, I slept a total of:** *(# of hours)*	**My sleep was disturbed by:** *(e.g., stress, snoring, pain, noise)*	**I consumed caffeinated drinks in the:** *(e.g., coffee, tea, cola)*	**I exercised at least 20 mins in the:**	**2-3 hours before bed, I consumed:**	**Medication(s) I took during the day:** *(List)*	**About 1 hour before sleep, I did the following:** *(TV, homework, texted)*
DAY 1 ______ DATE	PM / AM	PM / AM	Minutes	Times	❏ Refreshed ❏ Somewhat refreshed ❏ Fatigued	Times		❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Sugary food ❏ A heavy meal ❏ None		
DAY 2 ______ DATE	PM / AM	PM / AM	Minutes	Times	❏ Refreshed ❏ Somewhat refreshed ❏ Fatigued	Times		❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Sugary food ❏ A heavy meal ❏ None		
DAY 3 ______ DATE	PM / AM	PM / AM	Minutes	Times	❏ Refreshed ❏ Somewhat refreshed ❏ Fatigued	Times		❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Sugary food ❏ A heavy meal ❏ None		

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	COMPLETE IN MORNING							COMPLETE AT END OFDAY				
Fill out days 4-7 below	**Bedtime**	**Waketime**	**Time to fall asleep**	**I woke up during the night:** ***(# of times)***	**When I woke up, I felt:** ***(Check one)***	**Last night, I slept a total of:** ***(# of hours)***	**My sleep was disturbed by:** ***(e.g. stress, snoring, pain, noise)***	**I consumed caffeinated drinks in the:** ***(e.g., coffee, tea, soda)***	**I exercised at least 20 mins in the:**	**2-3 hours before bed, I consumed:**	**Medication(s) I took during the day:** ***(List)***	**About 1 hour before sleep I did the following:** ***(TV, homework, texted)***
DAY 4 DATE	PM / AM	PM / AM	Minutes	Times	❏ Refreshed ❏ Somewhat refreshed ❏ Fatigued	Times		❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Sugary food ❏ A heavy meal ❏ None		
DAY 5 DATE	PM / AM	PM / AM	Minutes	Times	❏ Refreshed ❏ Somewhat refreshed ❏ Fatigued	Times		❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Sugary food ❏ A heavy meal ❏ None		
DAY 6 DATE	PM / AM	PM / AM	Minutes	Times	❏ Refreshed ❏ Somewhat refreshed ❏ Fatigued	Times		❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Sugary food ❏ A heavy meal ❏ None		
DAY 7 DATE	PM / AM	PM / AM	Minutes	Times	❏ Refreshed ❏ Somewhat refreshed ❏ Fatigued	Times		❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Morning ❏ Afternoon ❏ Within several hours before going to bed ❏ None	❏ Sugary food ❏ A heavy meal ❏ None		

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