

WEEK OF:

DAY

SUN

MON

TUES

WED

THU

FRI

SAT

COMPLETE AT BEDTIME

Influencing Factors

Did you get early morning light/sun exposure?

Did you exercise today?

If so, what time did you exercise?

Did you nap? How long and what time?

Did you consume any alcohol? How much?

If so, what time was your last alcoholic drink?

If you smoke, what time was your last cigarette?

How many caffeinated beverages did you drink?

What time was your last caffeinated beverage?

How long before bed was your last meal of the day?

Did you practice a relaxing activity for at least 20 minutes?
(i.e. listen to a guided relaxation, meditate, practice yoga)

How much time did you spend winding down before bed?

What was your daytime stress level?

Scale of 1 - 10 (minimal to overwhelming)

Is your sleep environment cool, dark and quiet?

Please rate how you felt today:

1 - extremely tired / 2 - very tired / 3- somewhat tired /
4 - fairly alert / 5 - wide awake

COMPLETE THE NEXT MORNING

Sleep Schedule

Time to bed

Time you fell asleep

How many times did you awaken in the night?

Approximately how long were you awake in total?

Time you got out of bed

Total hours of actual sleep

Medications (prescription, non-prescription, herbal)