

Sleep diary

Start date: _____

1. Print this document and track your sleep habits.
2. Take time each morning to complete the sleep diary.
3. Review your sleep at the end of each week. Are there any factors that are influencing how long you sleep, causing sleep disruptions, or changing how you rate your sleep quality each day?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
What time did you go to bed last night?							
Did you fall asleep:							
Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After some time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What time did you get out of bed this morning?							
Did you wake up during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how long were you awake?							
How many hours did you sleep last night?							
Yesterday, when did you exercise? (Morning, afternoon, evening, or not at all)							
Within three hours before going to bed, did you:							
Eat a large meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink alcohol or caffeine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke or vape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you avoid electronic screens for 30 minutes before bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you follow your bedtime routine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How would you rate the quality of your sleep? (1 very poor to 5 very good)							

For more information on this document, please contact 613-549-1232, ext. 1180