	Complete in	the morning	
Start Date:			
	Day 1	Day 2	Day 3
Date of Week:			
What time did you get into	PM	PM	PM
bed?			
	AM	AM	AM
What time did you try and go	PM	PM	PM
to sleep?			
	AM	AM	AM
How long did it take you to	PM	PM	PM
fall into sleep?			
	AM	AM	AM
What time did you wake up	PM	PM	PM
this morning?			
	AM	AM	AM
How many times did you wake	up during the night?		
No. of times:			
No. of minutes:			
Last night I slept a total of:	HRS, MINS	HRS, MINS	HRS, MINS
How would you rate your sleep	quality?		
Vami Da av			
Very Poor Poor	0	0	0
Fair	0	0	0
Good	0	0	0
Very Good	0	0	0
Was your sleep disturbed by			
any factors? (e.g., allergies,			
noise, pets,			
discomfort/pain, etc.)			
Any other comments about			
your sleep worth noting			

Complete in the morning					
Start Date:					
	Day 4	Day 5	Day 6	Day 7	
Date of Week:					
What time did you get	PM	PM	PM	PM	
into bed?	***		4.4	***	
	AM	AM	AM	AM	
What time did you try	PM	PM	PM	PM	
and go to sleep?					
	AM	AM	AM	AM	
How long did it take you	PM	PM	PM	PM	
to fall into sleep?					
	AM	AM	AM	AM	
What time did you wake	PM	PM	PM	PM	
up this morning?					
	AM	AM	AM	AM	
How many times did you w	rake up during the nig				
		5			
No. of times:					
No. of minutes:					
Last night I slept a total	HRS, MINS	HRS, MINS	HRS, MINS	HRS, MINS	
of:					
How would you rate your s	leep quality?				
Very Poor	0	0	0	0	
Poor	0	0	0	0	
Fair	0	0	0	0	
Good	0	0	0	0	
Very Good	0	0	0	0	
Was your sleep					
disturbed by any					
factors? (e.g., allergies, noise, pets,					
discomfort/pain, etc.)					
Any other comments					
about your sleep worth					
noting					

Complete in the evening							
Date of Week:	Day 1	Day 2	Day 3				
I consumed caffeinated drinks in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
M/A/E/NA	PM	PM	PM				
	AM	AM	AM				
How many?	PM AM	PM AM	PM AM				
How much exercise did you get t							
No. of times:							
No. of minutes:							
Time of day (morning, afternoon, evening, night)							
Did you take a nap? (Circle one)	Yes	Yes	Yes				
	No	No	No				
If yes, for how long							
List all the medication you took today							
Approximately 2-3 hours before	bed, I consumed						
Alcohol							
A heavy meal							
Caffeine							
Not applicable							
In the hour before going to sleep, my bedtime routine included: (List activities including reading a book, using electronics, taking a bath, doing relaxation exercises, etc.)							

	Complete in th	e evening		
Date of Week:	Day 4	Day 5	Day 6	Day 7
I consumed caffeinated drir	nks in the: (M)orning,	(A)fternoon, (E)vening	s, (N/A)	
N4/A (F /NIA	PM	PM	PM	PM
M/A/E/NA	AM	AM	AM	AM
	PM	PM	PM	PM
How many?	AM	AM	AM	AM
How much exercise did you	get today?			
No. of times:				
No. of minutes:				
Time of day (morning, afternoon, evening, night)				
Did you take a nap? (Circle one)	Yes	Yes	Yes	Yes
	No	No	No	No
If yes, for how long				
List all the medication you took today				
Approximately 2-3 hours be	fore bed, I consume	d		
Alcohol				
A heavy meal				
Caffeine				
Not applicable				
In the hour before				
going to sleep, my				
bedtime routine				
included:				
(List activities including reading a				
book, using				
electronics, taking a				
bath, doing relaxation				
exercises, etc.)				