SLEEP HEALTHCENTERS®
...better sleep. better health.

SLEEP DIARY

NAME: ______________________________

WEEK OF: ______________________________

Day	Duration of Naps (minutes)	Bedtime	Time to Fall Asleep (minutes)	Number of Awakenings	Duration of Awakenings (minutes)	Final Waketime	Out of Bed Time	Time Spent Asleep (hours)	Medications Taken	Next Day Alertness 1-10 (10=most alert)
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

- Please begin to complete the sleep diary on a daily basis. It will provide a subjective tracking of your sleep schedule for you and your sleep clinician to use as you work together to improve your sleep.
- Do not look at the clock to complete this form. You should complete this diary each morning with respect to your previous night of sleep. Do not complete it during the night or keep it in your bedroom.
- Use it only as a guideline and spend no more than 30 seconds filling it out in the morning.