

INSTRUCTIONS FOR SLEEP DIARIES

DATES:.....Date last night and today.

BEDTIME:.....Time you went to bed last night.

TIME TO FALL

ASLEEP:.....How long you "think" it took you to fall asleep last night?

OF AWAKENINGS:.....How many times do you think you woke up last night?

TIME AWAKE:.....About how long do you think you were awake each time you woke up last night?

ACTIVITY:.....What you did while you were awake last night (i.e. Lie in bed, read, watch TV, eat, drink, etc.)

FINAL WAKE TIME:.....What time did you wake up this morning?

HOURS SLEPT:.....How long did you sleep last night?

LEVEL OF REST: Rate how you feel in the morning, noon, and in the evening. Example 1=not rested at all, 5=moderately rested, 10=fully rested.

ENERGY LEVEL:.....Rate how energetic you feel today in the morning, noon, and in the evening. Example: 1=no energy, 5=moderate energy, 10=full of energy.

HOURS AT WORK:.....How many hours did you work yesterday?

OF NAPS & TIME:.....Did you take a nap yesterday? If so, at what time and for how long?

PRIMARY EVENING

ACTIVITY:.....What you did last night. (i.e. watch TV, read, go fishing, talk with friends, etc.)

SLEEP RELATED

DIFFICULTY:.....List any activities that you have difficulty with due to sleepiness throughout your day today (i.e. driving, working, watching TV, reading, etc.)

STRESSORS:.....What kind of stressors did you experience yesterday? Did anything out of the ordinary happen to you ?

CAFFEINE:..... How much caffeine did you have yesterday? Please include how much coffee, cola, chocolate and anything else that you had.

TIME OF LAST CAFFEINE

INTAKE:.....When did you have your last beverage. Also include at what time you had your last piece of chocolate.

ALCOHOL:..... How much alcohol did you have yesterday and at what time?

MEDICATIONS:.....List any medication you had last night.

MEDICATIONS BEFORE

BEDTIME:.....List any medication you had before bedtime.