

# Daily Sleep Diary

Complete the diary every day in the morning when you wake up and at the end of the day before you go to sleep. The sleep diary only takes a few minutes each day to complete. To improve your sleep, learn about [sleep hygiene](#) and make small changes. Changing one habit at a time can set you on the path to a healthier sleep.

## Part 1: Fill out in the morning

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
	Day of the week: _____	Day of the week: _____	Day of the week: _____	Day of the week: _____	Day of the week: _____	Day of the week: _____	Day of the week: _____
What time did you go to bed last night?							
Did you fall asleep:							
<b>Easily</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>After some time</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>With difficulty</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After falling asleep, how many times did you wake up in the night?							
How many hours total did you sleep last night?							
What time did you <b>wake up</b> this morning?							
What time did you <b>get out of bed</b> this morning?							
When you woke up, did you feel:							
<b>Refreshed and rested</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Somewhat rested</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Fatigued</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date: October 8, 2024

Created by: Calgary Brain Injury Program

## Part 2: Fill out at the end of the day

Part 2: Fill out at the end of the day							
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
	Day of the week: _____	Day of the week: _____	Day of the week: _____	Day of the week: _____	Day of the week: _____	Day of the week: _____	Day of the week: _____
What medicines did you take today?							
How much caffeine did you drink today?							
How much alcohol did you drink today?							
How many minutes of exercise did you do today?							
Did you take a nap today? Yes/No If yes, how long was the nap?	<input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____
<b>Bedtime routine:</b> In the hour before going to sleep, what did you do? For example, read a book, used electronics, watched TV, took a bath, did a relaxation exercise.							