A Good Night's Sleep Center Weekly Sleep Log

Please fill this out as accurately and honestly as you can. Bring it with you to your next appointment to review with your doctor.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time to Sleep Last Night							
Time to Wake This Morning							
Quality of Your Sleep 1-10 (10 = poorly)							
How long did it take you to fall asleep last night?							
If you had trouble falling asleep, what kept you awake?							
How many times did you wake up last night?							
If you woke up during the night, what was the reason you awoke?							
If you woke up, how long did it take you to get back to sleep?							
Did you snore or have a choking sensation while sleeping last night? Any tossing & turning, kicking, hitting during the night?							
Did you dream last night?							
How tired were you during the day today?							
Did you nap during the day? If so, for how long and when?							
Did you have any significant stress or anxiety during the day? Depression?							
Did you drink alcohol or caffeinated beverages?							
Did you smoke today? If so, was it a pipe/ cigar/cigarette?							
Did you take any medications today?							

Name:____ Dates: From:_______________ to:____________________

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