

SLEEP DIARY

NAME: _____

Example shown at bottom of log.

Fatigue Rating Scale	0	25	50	75	100
	extremely fatigued	moderately fatigued	mildly fatigued	somewhat fatigued	very energetic

COMPLETE AT NIGHT in reference to today

COMPLETE IN MORNING in reference to night before

Day and Date	Unusual daytime stressors	Fatigue rating (use rating scale on top of page)	Naps (time & length)	Exercise (Y/N, time of day and how long)	Caffeine (note type and time) <i>Cigarettes</i>	Sleep meds or alcohol (name & dose)	Time you went to bed and turned out the lights	How long it took you to fall asleep for the first time	Number of times you woke up after falling asleep	How long you were awake in total after falling asleep	Time you finally woke up	Time you finally got out of bed
Mon. 9/14	Pain/ Stress	68	2-4 pm	No	Coffee, 8oz at noon	Ambien 10mg	12:00	60 min.	3	60 min.	6:30	8:00

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NAME: _____

Example shown at bottom of log.

Fatigue Rating Scale	0 extremely fatigued	25 moderately fatigued	50 mildly fatigued	75 somewhat fatigued	100 very energetic
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COMPLETE IN MORNING in reference to night before

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