HappyBrainWaves.com SLEEP DIARY ADULT

Print at least 2 copies for your personal use.

Answer the 17 questions as your Initial Survey, to get an understanding of what to do.

Answer the questions **each day** over the next 2 weeks. The aim is to measure the pattern and quality of your sleep, and factors that may affect your sleep over two weeks.

Your Name……. Date…….

Initial or Final Survey 7 day Record

	Survey	1	2	3	4	5	6	7
1/ Last night I *went to bed* to sleep at.....								
2/ Estimate *minutes* it took for you *to go to sleep*.								
3/ How many *times* did you *fully wake up*?								
4/ I *woke up* for the day at?								
5/ *How much sleep* did you have? Hours/minutes								
6/ Do you *feel refreshed*? On a scale of 1-4 1-No, 2 Just OK, 3Fine, 4 Very								
7/ Rate your *sleep quality* last night. 1-Very poor, 2 Poor, 3 OK, 4 Good, 5 Very good								
8/ Rate your *sleep quantity* last night. 1-Very inadequate, 2 Adequate, 3 OK, 4 Too much								
9/ Did you take *any sleeping tablets* last night?								
10/ Are you *on medication*? See footnote*								
11/ Did you have *any alcohol* last night? Yes/No Number of standard glasses.								
12/How many *caffeine drinks* (tea, coffee, cola etc) in 4 hours before bed?								
13/ How many *naps* yesterday?								
14/ How long did your naps last? (*Total mins*.)								
15/ Do any physical *exercise*? Yes/No **								
16/ How many *minutes of exercise*?								
17/ Are you *particularly* stressed, anxious, ill or depressed? Yes/No Circle if applicable.								

Footnote * **Medication**. Are sleeping difficulties a side effect? Check with your Health Consultant/Doctor

****Exercise/Activity** includes brisk walking. jogging, dancing, swimming, gardening etc

Ref:sleepdiary/word