

Sleep Diary



Sleep is an integral part of health and wellness. If poor sleep quality is making it hard to concentrate on your work, makes you stressed, or physically tired, this diary is a good place to start to track what's happening. You may find slight changes to your routine may help you get more rest.

Directions: Use this sleep diary to track your daily sleep habits over one week (7 days). Before going to bed, reflect on your daily habits, mood, and activities. When you wake up, note how you're feeling and anything that delayed or supported your sleep the night before. At the end of the week, review your completed diary and complete the Eagle's Rest [Sleep Assessment](#) to see if there are any patterns or practices that are helping or hindering your sleep. If you're experiencing major sleep disturbances that interfere with your well-being, consider scheduling an appointment with your doctor.

Day 1	Today is: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat							Total hours of sleep last night? _____
	BEFORE BED Bedtime: _____ Time last I had food drugs alcohol caffeine: _____ Took a nap? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what time? _____ Mood: 😊 😐 😞 Energy Level: 🦋🦋🦋🦋🦋🦋 1-2 hours before bed, I had: <input type="checkbox"/> sleep aid (or other medicine) <input type="checkbox"/> physical activity <input type="checkbox"/> screen time (e.g., phone/tv/computer)				AFTER BED How long did it take to fall asleep? _____ Woke up during the night? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why? _____ What time did I wake up? _____ Did I hit the snooze button? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A I woke up feeling: <input type="checkbox"/> well-rested <input type="checkbox"/> tired <input type="checkbox"/> other _____			

Day 2	Today is: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat							Total hours of sleep last night? _____
	BEFORE BED Bedtime: _____ Time last I had food drugs alcohol caffeine: _____ Took a nap? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what time? _____ Mood: 😊 😐 😞 Energy Level: 🦋🦋🦋🦋🦋🦋 1-2 hours before bed, I had: <input type="checkbox"/> sleep aid (or other medicine) <input type="checkbox"/> physical activity <input type="checkbox"/> screen time (e.g., phone/tv/computer)				AFTER BED How long did it take to fall asleep? _____ Woke up during the night? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why? _____ What time did I wake up? _____ Did I hit the snooze button? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A I woke up feeling: <input type="checkbox"/> well-rested <input type="checkbox"/> tired <input type="checkbox"/> other _____			

Day 3	Today is: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat							Total hours of sleep last night? _____
	BEFORE BED Bedtime: _____ Time last I had food drugs alcohol caffeine: _____ Took a nap? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what time? _____ Mood: 😊 😐 😞 Energy Level: 🦋🦋🦋🦋🦋🦋 1-2 hours before bed, I had: <input type="checkbox"/> sleep aid (or other medicine) <input type="checkbox"/> physical activity <input type="checkbox"/> screen time (e.g., phone/tv/computer)				AFTER BED How long did it take to fall asleep? _____ Woke up during the night? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why? _____ What time did I wake up? _____ Did I hit the snooze button? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A I woke up feeling: <input type="checkbox"/> well-rested <input type="checkbox"/> tired <input type="checkbox"/> other _____			

Day 4

Today is: Sun Mon Tues Wed Thurs Fri Sat Total hours of sleep last night? _____

BEFORE BED

Bedtime: _____
Time last I had food | drugs | alcohol | caffeine: _____
Took a nap? Yes No If yes, what time? _____
Mood: 😊 😐 😞 Energy Level: 🦋🦋🦋🦋🦋🦋
1-2 hours before bed, I had: sleep aid (or other medicine)
 physical activity screen time (e.g., phone/tv/computer)

AFTER BED

How long did it take to fall asleep? _____
Woke up during the night? Yes No If yes, why? _____
What time did I wake up? _____
Did I hit the snooze button? Yes No N/A
I woke up feeling: well-rested tired other _____

Day 5

Today is: Sun Mon Tues Wed Thurs Fri Sat Total hours of sleep last night? _____

BEFORE BED

Bedtime: _____
Time last I had food | drugs | alcohol | caffeine: _____
Took a nap? Yes No If yes, what time? _____
Mood: 😊 😐 😞 Energy Level: 🦋🦋🦋🦋🦋🦋
1-2 hours before bed, I had: sleep aid (or other medicine)
 physical activity screen time (e.g., phone/tv/computer)

AFTER BED

How long did it take to fall asleep? _____
Woke up during the night? Yes No If yes, why? _____
What time did I wake up? _____
Did I hit the snooze button? Yes No N/A
I woke up feeling: well-rested tired other _____

Day 6

Today is: Sun Mon Tues Wed Thurs Fri Sat Total hours of sleep last night? _____

BEFORE BED

Bedtime: _____
Time last I had food | drugs | alcohol | caffeine: _____
Took a nap? Yes No If yes, what time? _____
Mood: 😊 😐 😞 Energy Level: 🦋🦋🦋🦋🦋🦋
1-2 hours before bed, I had: sleep aid (or other medicine)
 physical activity screen time (e.g., phone/tv/computer)

AFTER BED

How long did it take to fall asleep? _____
Woke up during the night? Yes No If yes, why? _____
What time did I wake up? _____
Did I hit the snooze button? Yes No N/A
I woke up feeling: well-rested tired other _____

Day 7

Today is: Sun Mon Tues Wed Thurs Fri Sat Total hours of sleep last night? _____

BEFORE BED

Bedtime: _____
Time last I had food | drugs | alcohol | caffeine: _____
Took a nap? Yes No If yes, what time? _____
Mood: 😊 😐 😞 Energy Level: 🦋🦋🦋🦋🦋🦋
1-2 hours before bed, I had: sleep aid (or other medicine)
 physical activity screen time (e.g., phone/tv/computer)

AFTER BED

How long did it take to fall asleep? _____
Woke up during the night? Yes No If yes, why? _____
What time did I wake up? _____
Did I hit the snooze button? Yes No N/A
I woke up feeling: well-rested tired other _____

Complete the Eagles' Rest Sleep Assessment (link below or scan the QR Code) to see how you can make changes for a better night's sleep: <http://tinyurl.com/AUSleep>

