SLEEP DIARY

Please complete the diary each morning for the night before.

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
A	What time did you get into bed last night?							
B	What time did you turn the lights out?							
C	What time did you get to sleep (estimate)?							
D	What time did you finally wake up this morning (and not go back to sleep?)							
E	What time did you get out of bed this morning to start your day?							
F	How many times did you wake up during the night?							
G	How long were you awake last night in total? (add together all your time awake from the point of turning out the light to the point of getting out of bed this morning)							
H	Total time spent in bed (Time between A and E)							
I	Total Time asleep (the time between C and D, minus G)							
J	Sleeping medication taken							
How well do you feel this morning? 0 1 2 3 4 Not at all moderately Very								
How enjoyable was your sleep last night? 0 1 2 3 4 Not at all moderately Very								

Contact us: www.goodsleep.clinic | Phone: 07943 836168 | Email: hello@goodsleep.clinic
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