Sleep Diary

PATIENT INFORMATION

Name: _____ Age: _____

Sex: _____

Contact details (email address and phone number):

Current Medication

Existing Health Conditions

Date: _____ dd / mm / yyyy Bedtime Last Night: _____

Sleep Onset Latency (SOL): _____

Number of Awakenings: _____ Wake Time: _____

Total Sleep Time (TST): _____

Sleep Quality - Rate your sleep quality on a scale of 1-5

○ ○ ○ ○ ○
1 2 3 4 5

Daytime Functioning - Rate your level of alertness/functioning on a scale of 1-5

○ ○ ○ ○ ○
1 2 3 4 5

Napping

Observations

Overall Interpretation