

SleepWell® Tracker

Make enough copies for every day you are tracking your sleep.

Complete in the morning

Complete in the evening

	Date:	Date:	Date:
Time I went to bed			
Time I got out of bed			
I woke up during the night (# of times)			
Total hours of sleep			
What best describes the day today?	Work Vacation	Day Off School	Work Vacation
Energy upon waking 1 (Exhausted) – 5 (Refreshed)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
My sleep was disturbed by (check all that apply)	<input type="checkbox"/> Noise <input type="checkbox"/> Lights <input type="checkbox"/> Partner in bed <input type="checkbox"/> Temperature <input type="checkbox"/> Bodily discomfort <input type="checkbox"/> Illness or allergies <input type="checkbox"/> Stress or worry	<input type="checkbox"/> Noise <input type="checkbox"/> Lights <input type="checkbox"/> Partner in bed <input type="checkbox"/> Temperature <input type="checkbox"/> Bodily discomfort <input type="checkbox"/> Illness or allergies <input type="checkbox"/> Stress or worry	<input type="checkbox"/> Noise <input type="checkbox"/> Lights <input type="checkbox"/> Partner in bed <input type="checkbox"/> Temperature <input type="checkbox"/> Bodily discomfort <input type="checkbox"/> Illness or allergies <input type="checkbox"/> Stress or worry
Work shift (if applicable, e.g., night shift, 3rd shift)			
Ate breakfast/meal upon waking	Yes No	Yes No	Yes No
I consumed caffeine drinks (fill in # of cups)	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +
I exercised for at least 20 minutes	Yes No	Yes No	Yes No
I napped today (if yes, record how long)	Yes: _____ No	Yes: _____ No	Yes: _____ No
Level of daytime drowsiness (1 – no issues, 5 – very likely to doze off)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
My mood throughout the day (circle or describe)	😊 😐 😞	😊 😐 😞	😊 😐 😞
Activities in the hour before bedtime			

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My mood throughout the day (circle or describe)	😊 😐 😞	😊 😐 😞	😊 😐 😞	😊 😐 😞
Activities in the hour before bedtime				