Sleep Log

Name:_____ Birth Date:_____ Date: _____

	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Did you nap? How often? How long? When?							
Did you consume any alcohol or non-prescribed drugs? How much? When?							
Are you now taking prescribed medication? What? How much? When?							
Have you had any liquid other than water (tea, coffee, carbonated beverages)? What? How much? When?							
How long did it take you to fall asleep?							
When did you go to bed?							
Did you wake up during the night? How often? How long all together?							
What time was your final awakening?							
What time did you get out of bed?							
How did you feel upon awakening?							
How long did you sleep last night?							

Fill out every morning, regarding the prior 24 hours, and bring with you to your appointment