SLEEP HYGIENE LOG

PharmazZz
Non-medication Therapy for Insomnia

(Enter information each evening just before going to bed)

Date/Day									Average
Caffeinated drinks?	If yes, how many								
Before 5PM									
After 5PM									
Alcoholic drinks	If yes, how many								
Before 5PM									
After 5PM									
Nicotine use	If yes, how many cigarettes (or other units)?								
Before 5 PM									
After 5 PM									
Exercise	If yes, no. of minutes?								
Before 5 PM									
After 5 PM									
Naps?	If yes, note time and length								
What time?									
No. of minutes?									
Stressful happenings during your day? _Y/N_									
Did you feel sleepy during the day? _Y/N_									
Rate and describe your mood today.	1=poor, 2=fair, 3=good, 4=excellent								
Overall functioning during the day?	1=poor, 2=fair, 3=good, 4=excellent								
Other items?									