



Name: _____												
Did you consume caffeine (e.g. coke, coffee) in the hour before bed? Yes / No <i>(please circle)</i> If yes, how often? Every night / 3-4 nights per week / 1-2 nights per week <i>(please circle)</i>												
Date	Day	Total time of all daytime naps (mins)	Time went to bed in evening	After going to your bedroom, what did you do? <i>(Tick all that apply)</i>	Time went to sleep	Number of awakenings during the night	Total time awake during the night (mins)	Time woke up next morning	Who or what woke you up in the morning <i>(Please tick)</i>	Time got out of bed	Total Sleep Time <i>(see instructions for calculation)</i>	Mood Scale <i>(see instructions)</i>
				<input type="checkbox"/> Went straight to sleep <input type="checkbox"/> Watched TV <input type="checkbox"/> Read a book <input type="checkbox"/> Used electronic device <input type="checkbox"/> Listened to music <input type="checkbox"/> Talked/text on phone <input type="checkbox"/> Other : _____					<input type="checkbox"/> Woke myself <input type="checkbox"/> A family member <input type="checkbox"/> Alarm clock <input type="checkbox"/> Other: _____			
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What was the one thing you changed about your sleep habits? _____

What effect did this one change have on:

- The amount of sleep you got? _____
- The number of time you woke up during the night? _____
- How easy it was to wake up in the morning? _____



d. Your mood? _____