CHANGE ACADEMY

50,000 Mile Tune-Up

SYSTEM #6: BRAKES

STEP 1: KEEP A SLEEP DIARY

Complete your sleep dary (see next page) every day, ideally within 3 hours of waking up every morning.

STEP 2: REVIEW THE DATA

Once you've gathered some data, consider the following questions

- Do I feel well-rested when I wake up?
- Do I feel drowsy during the day?
- Am I spending significant time lying in bed without being able to fall asleep?
- Is my sleep schedule consistent or does it fluctuate?
- Am I taking naps that are too long or too late in the day that could be affecting my nighttime sleep?
- Is my sleep disrupted in the night? If so, is there any pattern in the diary that might explain why?
- Is my use of alcohol, caffeine, and/or medications affecting my sleep time or sleep quality?

STEP 3: SHARE YOUR OBSERVATIONS

If you consult with a sleep medicine specialist, share your log It may provide some useful clues. Find a sleep medicine specialist:

BehavioralSleep.org

CBT-I Practioner Directory

Sleep Log

Please fill this out for the previous day and night no more than 3 hours after waking.
The information can be an estimate when necessary.

SleepFoundation
A OneCare Media Company

NAME _____ WEEK OF _____

DAY	SUN	MON	TUES	WED	THURS	FRI	SAT
Did you nap?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For how long?	mins.	mins.	mins.	mins.	mins.	mins.	mins.
At what time?							
Did you have any caffeine* after 6pm?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you drink alcohol after 6pm?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you use nicotine after 6pm?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you exercise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you eat a heavy meal or snack after 6pm?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you take any sleeping medication	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
What medication?							
Amount							
At what time?							
Were you sleepy during the day?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NIGHT							
What time did you turn off the lights to go to sleep?							
What time did you wake up?							
How many total hours did you sleep?							
How many times did you wake up in the night?							
Rate the quality of your sleep:	○○○○○	○○○○○	○○○○○	○○○○○	○○○○○	○○○○○	○○○○○
Do you feel you got enough sleep?							

* Caffeine = coffee, tea, caffeinated soda, chocolate, energy drinks, certain medications.