

NJ Recovery & Wellness

Morning Sleep Dairy

Day of the week:	Day 1: Sun	Day 2: Mon	Day 3: Tues	Day 4: Wed	Day 5: Thur	Day 6: Fri	Day 7: Sat	
What time did you get <i>into</i> bed?	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	
What time did you <i>try</i> to go to sleep?	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	
What time did you <i>wake</i> up this morning/evening?	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	AM: PM:	
Did you wake up during the night?	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	
If you, did you get up?	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	
Total Sleep Time?	HR: Min:	HR: Min:	HR: Min:	HR: Min:	HR: Min:	HR: Min:	HR: Min:	
What would you rate your quality?	Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Very Poor <input type="radio"/>	Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Very Poor <input type="radio"/>	Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Very Poor <input type="radio"/>	Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Very Poor <input type="radio"/>	Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Very Poor <input type="radio"/>	Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Very Poor <input type="radio"/>	Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Very Poor <input type="radio"/>	Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Very Poor <input type="radio"/>
Did you check your phone right away?	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	

Name: _____

Start Date: _____



NJ Recovery & Wellness

Evening Sleep Dairy

Day of the week:	Day 1: Sun	Day 2: Mon	Day 3: Tues	Day 4: Wed	Day 5: Thur	Day 6: Fri	Day 7: Sat
I consumed <i>Caffeine</i> in the: <i>Morning</i> 5 am to 10 am (AM), <i>Afternoon</i> 10 am to 2 pm (PM), <i>Early-Evening</i> 2 pm to 6 pm (EE), <i>Nighttime</i> 6 pm to 10 pm (NT), Not applicable (NA)							
AM, PM, EE, NT, NA							
If so, how many cups (8oz)?							
Did you exercise for at least 30 minutes today?	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>
Time of day for the workout? AM, PM, EE, NT, NA							
Did you consume Alcohol?	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>	Yes: <input type="radio"/> No: <input type="radio"/>
2-4 hours before bed, did you consume any of the following?							
Caffeine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dairy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What I did before going to sleep? (ex. shower, movie, reading a physical book, using phone or computer, talking to friend or family)							