



Child's Sleep Diary, complete in morning

Start Date: / / Day of the Week:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
My child got into bed last night at:	PM/AM	PM/AM	PM/AM	PM/AM	PM/AM	PM/AM	PM/AM
Last night my child fell asleep:							
Easily:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After some time:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With difficulty:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child woke up during the night:							
# of times							
# of minutes							
My child got out of bed today at:	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM
Last night my child slept a total of:	Hours	Hours	Hours	Hours	Hours	Hours	Hours
My child's sleep was disturbed by: noise, lights, temperature, pets, allergies, nightmares, stress, discomfort, pain, etc.							
When my child woke up for the day, he/she felt:							
Rested:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somewhat rested:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes: Record any other factors that may affect your child's sleep							

Complete at the end of the day

Day of the week:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
My child consumed caffeinated items in the: (M)orning, (A)fternoon, (E)vening, (N/A) (e.g., chocolate, soda)							
M/A/E/NA							
How much?	_____	_____	_____	_____	_____	_____	_____
My child exercised at least 20 minutes in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
M/A/E/NA							
My child took these medications today:							
Took a nap? (circle one)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No	No
If yes, for how long?							
During the day, how likely was your child to nod off or even fall asleep while performing daily tasks: No chance (NC), Slight chance (SC), Moderate chance (MC), High chance (HC)							
NC/SC/MC/HC							
Throughout the day, my child's mood was... Very pleasant (VP), Pleasant (P), Unpleasant (UP), Very unpleasant (VUP)							
VP/P/UP/VUP							
In the hour before going to sleep, my child's bedtime routine included: List activities including reading a book, taking a bath, doing relaxation exercises, etc.							