Date: _____

Week 2, Day 1

Sleep

What time did you go to bed last night?

_____

How often did you wake up during the night? (No. of times) _____

Total number of hours slept? _____

How rested did you feel when you woke up this morning?
(circle on the scale below)

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
not at all *completely*

I Plan to...

I Did...

6:00 am		
7:00		
8:00		
9:00		
10:00		
11:00		
12:00 pm		
1:00		
2:00		
3:00		
4:00		
5:00		
6:00		
7:00		
8:00		
9:00		

Medications

What medications did you take today?

_____