INSOMNIA SYMPTOM TRACKER

Patient Name: _____ Month/Year: _____

Print Log

DATE	BEDTIME / RISE TIME	TIME TO FALL ASLEEP	NIGHT AWAKENINGS	SLEEP QUALITY (1-10)	DAILY FACTORS (CAFFEINE, STRESS, MEDS)

DATE	BEDTIME / RISE TIME	TIME TO FALL ASLEEP	NIGHT AWAKENINGS	SLEEP QUALITY (1-10)	DAILY FACTORS (CAFFEINE, STRESS, MEDS)

Sleep Quality: 1 (Poor) - 10 (Excellent) **Time to Fall Asleep:** Estimated minutes/hours **Awakenings:** Number of times + duration awake