SLEEP DISORDER ASSESSMENT LOG

Week Beginning: _____

Patient Name:

Provider:

Medications:

DATE	BED TIME	LATENCY (MINS TO FALL ASLEEP)	AWAKENINGS (# / DURATION)	WAKE TIME	TOTAL SLEEP HOURS	QUALITY (1-10)	DAYTIME SYMPTOMS (FATIGUE, FOCUS, MOOD)

WEEKLY OBSERVATIONS / TRIGGERS:

Quality: 1 (Poor) - 10 (Excellent) **Latency:** Estimated time spent awake before sleep onset. **Awakenings:** Number of times woken + total minutes spent awake during night.