Fibromyalgia Sleep Diary and Sleep Habit Worksheet

Instructions:

- Complete the following Sleep Diary and Sleep Habit Worksheet daily for 7 days, in the morning upon waking and again right before going to bed at night.

- At the end of seven consecutive days, take some time to look over the worksheet to identify our evening and bedtime habits that are negatively affect your ability to get restorative rest.

- Once you identify areas that may be impacting your ability to fall asleep, stay asleep or wake rested, you can then make lifestyle changes and adjust pre-bedtime habits.

- Once you have altered your habits, again, track your sleep for another 7 nights. What differences did you see?

This is good information for you. It can empower you create healthy habits that promote a good nights rest; healthy habits that can decrease the symptoms of Fibromyalgia and give the body a chance to repair itself during restorative sleep.

This is also good information so share with your doctor or healthcare practitioner. It may be that you have a sleep disorder that requires specific treatment or nighttime habits that need to be changed.

Medications: (talk with your local pharmacist regarding side effects)

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Is insomnia or difficulty falling or staying asleep listed as a side effect?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: If you are taking medication that lists insomnia or difficulty falling or staying asleep as a possible side effects, talk with your doctor or healthcare practitioner. Ask if there is there a different medication that you could take that would not impact your sleep? Is there a natural remedy, herb or treatment that treats that same symptoms as your medication without the side effect of negatively impacting your sleep?
General Sleep Environment Statements:

Yes  No  My bed, mattress and pillow are comfortable and supportive
Yes  No  My bedroom is dark
Yes  No  My bedroom is uncluttered
Yes  No  There is not a computer or TV in my bedroom
Yes  No  I use my bedroom for sleeping only
Yes  No  My bedroom feels like a restful place to be

Day 1 - Evening:

Yes  No  **Dinner** (within 4 hours of bedtime)
Yes  No  **Caffeine** (within 6 hours of bedtime)
Yes  No  **Alcohol** (within 1 hour of bedtime)
Yes  No  **Exercise** (within 3 hours of bedtime)

Pre-bedtime activity:

___High spirited conversation  ___ watching TV  ___ listening to soothing music
___out of the house, came home right before bed  ___bath  ___read a book/magazine
___talked on the phone  ___physical activity  ___visited with friends  ___other:

When I went to bed my mind felt: ___quiet ___racing with thoughts ___worried
___excited ___ anxious ___other:

Day 2 - Morning:

**Today I awoke feeling:**

___energetic  ___ have some energy ___ just OK  ___tired  ___exhausted

My pain level is: ___ higher than normal  ___ same a usual  ___less than usual.

Emotionally I feel: ________________________________________________________________

I went to bed at _________________ p.m. and  I woke up at ________________ a.m.

Overall, I slept _____ hours last night.

I woke up _______ times during the night due to ___ pain  ___ a dream  ___ noise
___ thirst ___ to use the bathroom ___ my own snoring ___ my partners snoring
___ hunger ___ to gasp for breath
Day 2 - Evening:

Yes No Dinner (within 4 hours of bedtime)
Yes No Caffeine (within 6 hours of bedtime)
Yes No Alcohol (within 1 hour of bedtime)
Yes No Exercise (within 3 hours of bedtime)

Pre-bedtime activity:

___High spirited conversation ___ watching TV ___ listening to soothing music
___out of the house, came home right before bed ___bath ___read a book/magazine
___talked on the phone ___physical activity ___visited with friends ___other :

When I went to bed my mind felt: ____quiet ____racing with thoughts ___worried
_____excited ___ anxious ___other:

Day 3 - Morning:

Today I awoke feeling :

___energetic ____ have some energy _____ just OK ___tired ___exhausted

My pain level is: ___higher than normal ___ same a usual ___less than usual.

Emotionally I feel: ________________________________________________________.

I went to bed at __________________ p.m. and I woke up at _______________ a.m.

Overall, I slept _____ hours last night.

I woke up ________ times during the night due to ___ pain ___ a dream ___ noise
___ thirst ___ to use the bathroom ___ my own snoring ___ my partners snoring
___ hunger ___ to gasp for breath
Day 3 - Evening:

Yes  No  Dinner (within 4 hours of bedtime)
Yes  No  Caffeine (within 6 hours of bedtime)
Yes  No  Alcohol (within 1 hour of bedtime)
Yes  No  Exercise (within 3 hours of bedtime)

Pre-bedtime activity:

___High spirited conversation ___ watching TV ___ listening to soothing music
___out of the house, came home right before bed ___ bath ___ read a book/magazine
___talked on the phone ___ physical activity ___ visited with friends ___ other:

When I went to bed my mind felt: ___ quiet ___ racing with thoughts ___ worried
___ excited ___ anxious ___ other:

Day 4 - Morning:

Today I awoke feeling:

___ energetic ___ have some energy ___ just OK ___ tired ___ exhausted

My pain level is: ___ higher than normal ___ same as usual ___ less than usual.

Emotionally I feel: ____________________________________________________________

I went to bed at __________________ p.m. and I woke up at _______________ a.m.

Overall, I slept _____ hours last night.

I woke up _______ times during the night due to ___ pain ___ a dream ___ noise
___ thirst ___ to use the bathroom ___ my own snoring ___ my partners snoring
___ hunger ___ to gasp for breath
Day 4 - Evening:

Yes  No   Dinner (within 4 hours of bedtime)
Yes  No   Caffeine (within 6 hours of bedtime)
Yes  No   Alcohol (within 1 hour of bedtime)
Yes  No   Exercise (within 3 hours of bedtime)

Pre-bedtime activity:

___High spirited conversation ___ watching TV ___ listening to soothing music
___out of the house, came home right before bed ___bath ___ read a book/magazine
___talked on the phone ___ physical activity ___ visited with friends ___ other:

When I went to bed my mind felt: ___ quiet ___ racing with thoughts ___ worried
___ excited ___ anxious ___ other:

Day 5 - Morning:

Today I awoke feeling:

___ energetic ___ have some energy ___ just OK ___ tired ___ exhausted

My pain level is: ___ higher than normal ___ same as usual ___ less than usual.

Emotionally I feel: ________________________________.

I went to bed at ______________ p.m. and I woke up at ______________ a.m.

Overall, I slept ____ hours last night.

I woke up ______ times during the night due to ___ pain ___ a dream ___ noise
___ thirst ___ to use the bathroom ___ my own snoring ___ my partners snoring
___ hunger ___ to gasp for breath
Day 5 - Evening:

Yes   No   Dinner (within 4 hours of bedtime)
Yes   No   Caffeine (within 6 hours of bedtime)
Yes   No   Alcohol (within 1 hour of bedtime)
Yes   No   Exercise (within 3 hours of bedtime)

Pre-bedtime activity:

___High spirited conversation ___ watching TV ___ listening to soothing music
___out of the house, came home right before bed ___bath ___read a book/magazine
___talked on the phone ___physical activity ___visited with friends ___ other:

When I went to bed my mind felt: ____ quiet ____ racing with thoughts ___ worried
_____ excited ___ anxious ___ other:

Day 6 - Morning:

Today I awoke feeling:

___energetic ___ have some energy ___ just OK ___ tired ___ exhausted

My pain level is: ___ higher than normal ___ same a usual ___ less than usual.

Emotionally I feel: ____________________________________________________________.

I went to bed at ________________ p.m. and I woke up at ____________ a.m.

Overall, I slept _____ hours last night.

I woke up ________ times during the night due to ___ pain ___ a dream ___ noise
___ thirst ___ to use the bathroom ___ my own snoring ___ my partners snoring
___ hunger ___ to gasp for breath
Day 6 - Evening:

Yes  No  Dinner (within 4 hours of bedtime)
Yes  No  Caffeine (within 6 hours of bedtime)
Yes  No  Alcohol (within 1 hour of bedtime)
Yes  No  Exercise (within 3 hours of bedtime)

Pre-bedtime activity:

___High spirited conversation ___ watching TV ___ listening to soothing music
___out of the house, came home right before bed ___bath ___ read a book/magazine
___talked on the phone ___ physical activity ___ visited with friends ___ other:

When I went to bed my mind felt: ____ quiet ____ racing with thoughts ____ worried
____ excited ____ anxious ____ other:

Day 7 - Morning:

Today I awoke feeling:

___ energetic ___ have some energy ____ just OK ____ tired ____ exhausted

My pain level is: ____ higher than normal ____ same as usual ____ less than usual.

Emotionally I feel: ______________________________________________________.

I went to bed at ________________ p.m. and I woke up at _______________ a.m.

Overall, I slept ____ hours last night.

I woke up _______ times during the night due to ___ pain ___ a dream ___ noise
___ thirst ___ to use the bathroom ___ my own snoring ___ my partners snoring
___ hunger ___ to gasp for breath
Day 7 - Evening:

Yes   No   Dinner (within 4 hours of bedtime)
Yes   No   Caffeine (within 6 hours of bedtime)
Yes   No   Alcohol (within 1 hour of bedtime)
Yes   No   Exercise (within 3 hours of bedtime)

Pre-bedtime activity:

___High spirited conversation ___ watching TV ___ listening to soothing music
___out of the house, came home right before bed ___ bath ___ read a book/magazine
___talked on the phone ___ physical activity ___ visited with friends ___ other:

When I went to bed my mind felt: ____ quiet ____ racing with thoughts ____ worried
_____ excited ___ anxious ____ other:

Day 8 - Morning:

Today I awoke feeling :

___ energetic ___ have some energy ___ just OK ___ tired ___ exhausted

My pain level is: ____ higher than normal ____ same as usual ____ less than usual.

Emotionally I feel: _____________________________________________________________.

I went to bed at ________________ p.m. and I woke up at ________________ a.m.

Overall, I slept _____ hours last night.

I woke up _______ times during the night due to ___ pain ___ a dream ___ noise
___ thirst ___ to use the bathroom ___ my own snoring ___ my partners snoring
___ hunger ___ to gasp for breath
**Note:**

If you answered NO to any of the **General Sleep Environment Statements**, you should consider making some changes in your bedroom to create a more supportive sleep environment.

If you answered YES to consuming **dinner, caffeine, alcohol** or engaging in **exercise** within the time frames indicated, you may want to consider making lifestyle adjustments to support better sleep habits.