



SHIFTWORK SERVICES SLEEP DIARY

Please answer when you wake up

	What time did you go to bed?	How long did it take you to fall asleep?	How many times did you wake up during your sleep, if at all?	In total about how many hours did you sleep?	At what time did you wake up (for the last time)?	On a scale of 1-5 how did you feel when you woke up?
Day 1						<input type="checkbox"/> 5 – very refreshed <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very tired
Day 2						<input type="checkbox"/> 5 – very refreshed <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very tired
Day 3						<input type="checkbox"/> 5 – very refreshed <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very tired
Day 4						<input type="checkbox"/> 5 – very refreshed <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very tired
Day 5						<input type="checkbox"/> 5 – very refreshed <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very tired
Day 6						<input type="checkbox"/> 5 – very refreshed <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very tired
Day 7						<input type="checkbox"/> 5 – very refreshed <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very tired



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Please answer at bedtime, before you go to sleep

	How long, if at all, did you nap during the day?	Substances e.g. caffeine, alcohol, medications taken during the day?	On a scale of 1-5 how would you rate you have felt during the day?
Day 1			<input type="checkbox"/> 5 – very energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very fatigued
Day 2			<input type="checkbox"/> 5 – very energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very fatigued
Day 3			<input type="checkbox"/> 5 – very energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very fatigued
Day 4			<input type="checkbox"/> 5 – very energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very fatigued
Day 5			<input type="checkbox"/> 5 – very energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very fatigued
Day 6			<input type="checkbox"/> 5 – very energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very fatigued
Day 7			<input type="checkbox"/> 5 – very energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – very fatigued