Starting Date:	Lights out time	Time it took to fall asleep (approx.)	Time you woke up in the morning	Quality of sleep (rate: 1-10)	How refreshed you felt in the morning (rate : 1-10)	Caffeine or alcohol consumption the day before? (Y/N)	3 main meals eaten with protein & carbs the day before? (Y/N & # of meals)	Stressful day (rate: 1-10)	Light exposure reduced 2 hr before bed?	No TV before bed (Y/N)	Relaxation technique performed before bed (Y/N)	Supplements taken before bed (Y/N)	Other Notes
Monday													
Tuesday													
Wednesday													
Thursday													
Friday													
Saturday													
Sunday													

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