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Top Ten Sleep Tips!

- Make your bedroom conducive to sleep. Consider the comfort of your bed, the air temperature, and levels of noise and light. Minimize interference with your sleep by bed partner, children, or pets.

- Caffeine is a stimulant and should be discontinued 6 hours before bedtime. Know the foods, drinks and medications that contain caffeine.

- Nicotine is a stimulant and should be avoided near bedtime.

- Alcohol is a depressant; although it may help you get to sleep, it causes awakenings later in the night. Do not drink alcohol later than 4 hours prior to bedtime.

- Sleeping pills alter the quality of sleep, and if used for several weeks or months will cause disturbed sleep when discontinued.

- A light snack may be sleep inducing, but a heavy meal close to bedtime interferes with sleep. Avoid consuming chocolate, large amounts of sugar, and excessive fluids close to bedtime.

- Do not exercise vigorously within 3 – 4 hours of bedtime. Regular exercise in the late afternoon may deepen sleep.

- Take time to wind down in the evening prior to going to bed.

- Have a regular bedtime and rise time, even on week-ends.

- If you can't sleep, get out of bed, go to another room and do a quiet activity until you are sleepy. Return to bed when sleepy.

Most Powerful Principles

- Constant rise time
- Don’t go to bed too early (Stay up Late!)
- Get out of bed when not sleeping
- Do something with racing thoughts

Sleep Diary Instructions

- You will be collecting some important information on your sleep patterns. You and I will use this information to understand your sleep problem and to measure your progress at improving your sleep.
- After you wake up in the morning, please answer all 10 questions. It is important that you complete the diary *every morning*, when it is freshest in your memory.
- It is often difficult to estimate the duration of wakefulness (numbers 3 and 4), so just provide your best *estimates*. Do not watch the clock!
- If there is an unusual event (e.g., illness, emergency, phone call) that may have affected your sleep, please make a note of it, indicating the date.
- The **DAY** and **DATE** refer to the morning that you are filling in the information. For example, DAY: Tuesday DATE: October 27, 2004 would head the column for information on Monday night's sleep.

1. *Napping*: This should include all naps even those which are not intentional. For example, if you dozed off in front of the television for 10 minutes, include this as a nap. Please specify A.M. or P.M.

2. *Bedtime*: This is the time that you go to bed and actually turn the lights off. If you go to bed at 10:45 but turn the lights off at 11:15, these are the times that you would write in the spaces.

3. *Sleep-Onset Latency*: Provide an estimate of how long it took you to fall asleep after you turned the lights off and intended to go to sleep.

4. *Number and Duration of Awakenings*: Please estimate how many times you woke up during the night and then estimate how many minutes you were awake for each awakening. If this is difficult, then estimate the number of minutes you spent for all awakenings combined. This should not include your very last awakening in the morning, as this will be logged in number 7.

5. *Morning Awakening*: This is the very last time you woke up in the morning. If you woke up at 4:00 and never went back to sleep, you would write 4:00 A.M. in this space. However, if you woke up at 4:00 but went back to sleep for a brief period of time, for example, from 6:00 to 6:20, then your last awakening would be 6:20 A.M.

6. *Out- of- Bed Time*: This is the time you actually got out of bed for the day.

7. *Rested Feeling upon Arising*: Please use the following 5-point scale:
   1=Exhausted; 2=Tired; 3=Average; 4=Rather refreshed; 5=Very refreshed

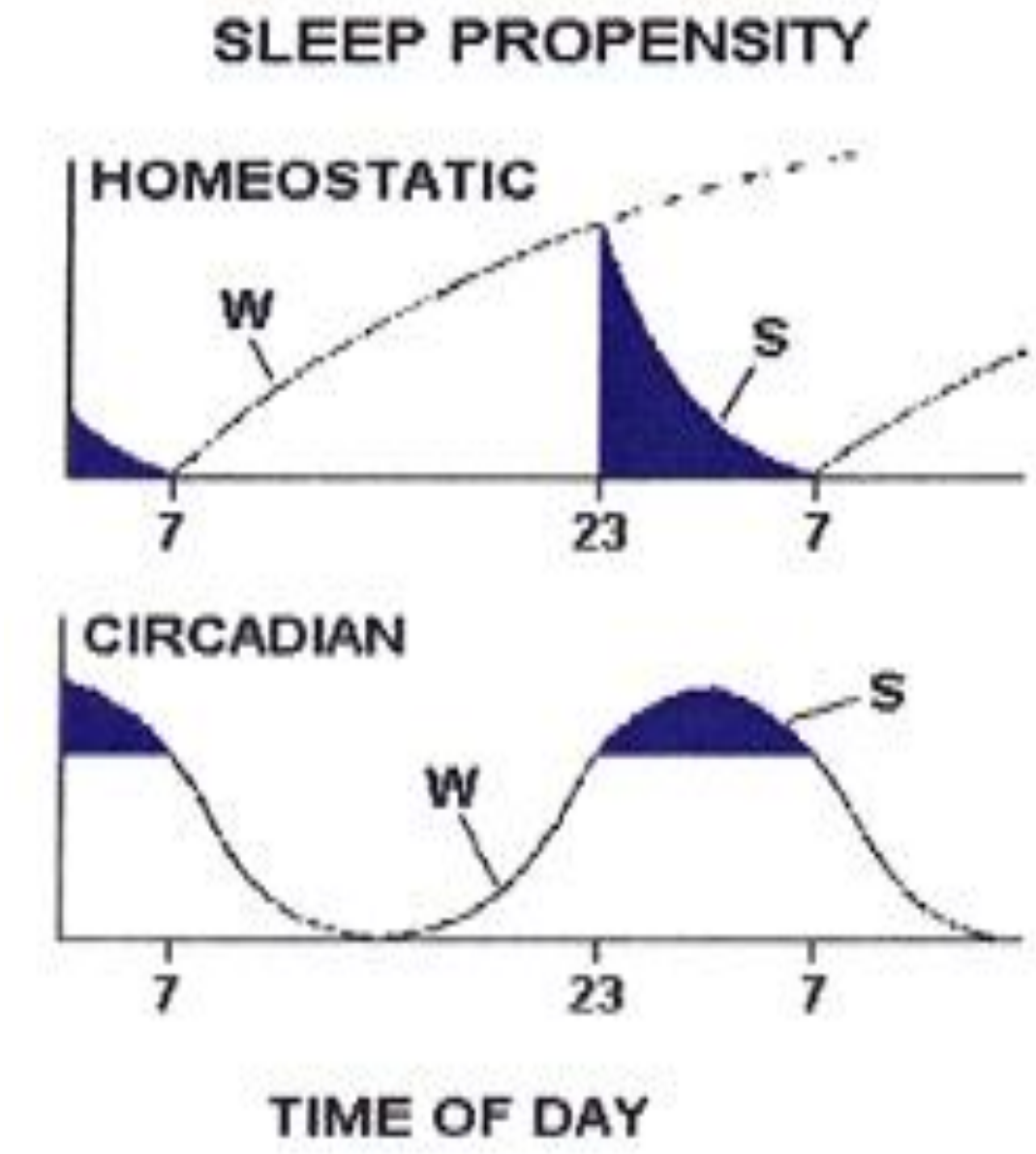
8. *Sleep Quality*: Please use the following 5-point scale:
   1=Very restless; 2=Restless; 3=Average quality; 4=Sound; 5=Very Sound

9. *Alcohol*: Specify time, type and amount taken (yesterday).

10. *Sleep Medication*: Include both prescribed and over-the-counter medications. Specify time, type and amount taken (yesterday or during the night).

SLEEP DIARY WEEK OF: _____ NAME: _____

DAY *(morning, upon awakening)*							
DATE							
1. I had __ naps yesterday.							
Note the time of day and duration of the nap(s).							
2. I went to bed at _____ *(time)* and							
turned out the lights at _____ *(time).*							
3. After turning out the lights, I fell asleep in ___ minutes.							
4. My sleep was interrupted ___ time(s).							
Specify duration, in minutes, of each awakening.							
5. I woke up at _____ *(time of last awakening).*							
6. I got out of bed at _____ *(time).*							
7. How rested do you feel this morning? *(1=exhausted; 5=very refreshed)*							
8. Rate the quality of last night's sleep. *(1=very restless; 5=very sound)*							
9. Alcohol *Time and amount*							
10. Sleeping medication *Time and amount*							



A. Borbely. Two-Process Model of Sleep Regulation

Epworth Sleepiness Scale

(Johns, 1991)

Name: _____

Date: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation: -

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading …….	_____
Watching TV …….	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting) …….	_____
As a passenger in a car for an hour without a break …….	_____
Lying down to rest in the afternoon when circumstances permit …….	_____
Sitting and talking to someone ……..	_____
Sitting quietly after a lunch without alcohol …….	_____
In a car, while stopped for a few minutes in the traffic …….	_____
TOTAL……..	_____

Thank you.

Score:

0 – 10 Normal range
10 - 12 Borderline
12 – 24 Abnormal