
SLEEP HELP CENTER

THE 7-DAY SLEEP JOURNAL

Better Nights. Brighter Days.

A practical, printable sleep diary to help you notice patterns in your evenings, nights, and mornings.

Name: _____

Week beginning: _____

SleepHelpCenter.com

Welcome • How to use your journal

For seven consecutive days, record your sleep as best you can. Estimates are fine. You do not need to watch the clock during the night. Complete the evening section before bed and the morning section shortly after waking.

What to record: bedtime, approximate time to fall asleep, wake-ups, final wake time, daytime habits, and how you feel. Track patterns, not perfection.

Useful definitions: “Time in bed” is the interval between getting into bed and getting out of bed. “Estimated sleep time” is time in bed minus time awake while trying to sleep and during nighttime awakenings. These estimates are not diagnostic measurements.

A gentle seven-day commitment

I will observe my sleep without judging myself. I will use these pages to learn what helps and what gets in the way.

What I hope to learn this week:

Important: This journal is educational and does not diagnose or treat a sleep disorder. If you have persistent sleep difficulties, loud snoring with breathing pauses, or excessive daytime sleepiness, consult a qualified healthcare professional. Do not drive when dangerously sleepy.

Before you begin • My sleep baseline

My usual routine	My answer
Typical bedtime	
Typical wake-up time	
Usual caffeine intake / last serving	
Evening screen habits	
Bedroom temperature, light, and noise	
Regular medicines or sleep aids (optional)	
Current sleep concern / goal	

What does a well-rested morning look like to me?

Day 1 • Evening check-in

Date: _____ Day of week: _____

Tonight's routine	Your notes
Caffeine today? Amount / last time	
Alcohol or nicotine today? (optional)	
Exercise / movement and timing	
Last meal or snack time	
Screen use in final hour before bed	
Stress level (0-10)	
Wind-down activity	
Planned bedtime	

One thing on my mind tonight:

Day 1 • Morning sleep diary

Date of waking: _____

Sleep measure	Your estimate
Time I got into bed	
Time I tried to fall asleep	
Minutes until I fell asleep	
Number of nighttime awakenings	
Total minutes awake overnight	
Final wake-up time	
Time I got out of bed	
Estimated total sleep hours	
Sleep quality (1 very poor – 5 very good)	
Rested feeling (1 not rested – 5 very rested)	
Naps yesterday (time / duration)	

What may have helped or disturbed my sleep?

Day 2 • Evening check-in

Date: _____ Day of week: _____

Tonight's routine	Your notes
Caffeine today? Amount / last time	
Alcohol or nicotine today? (optional)	
Exercise / movement and timing	
Last meal or snack time	
Screen use in final hour before bed	
Stress level (0-10)	
Wind-down activity	
Planned bedtime	

One thing on my mind tonight:

Day 2 • Morning sleep diary

Date of waking: _____

Sleep measure	Your estimate
Time I got into bed	
Time I tried to fall asleep	
Minutes until I fell asleep	
Number of nighttime awakenings	
Total minutes awake overnight	
Final wake-up time	
Time I got out of bed	
Estimated total sleep hours	
Sleep quality (1 very poor – 5 very good)	
Rested feeling (1 not rested – 5 very rested)	
Naps yesterday (time / duration)	

What may have helped or disturbed my sleep?

Day 3 • Evening check-in

Date: _____ Day of week: _____

Tonight's routine	Your notes
Caffeine today? Amount / last time	
Alcohol or nicotine today? (optional)	
Exercise / movement and timing	
Last meal or snack time	
Screen use in final hour before bed	
Stress level (0-10)	
Wind-down activity	
Planned bedtime	

One thing on my mind tonight:

Day 3 • Morning sleep diary

Date of waking: _____

Sleep measure	Your estimate
Time I got into bed	
Time I tried to fall asleep	
Minutes until I fell asleep	
Number of nighttime awakenings	
Total minutes awake overnight	
Final wake-up time	
Time I got out of bed	
Estimated total sleep hours	
Sleep quality (1 very poor – 5 very good)	
Rested feeling (1 not rested – 5 very rested)	
Naps yesterday (time / duration)	

What may have helped or disturbed my sleep?

Day 4 • Evening check-in

Date: _____ Day of week: _____

Tonight's routine	Your notes
Caffeine today? Amount / last time	
Alcohol or nicotine today? (optional)	
Exercise / movement and timing	
Last meal or snack time	
Screen use in final hour before bed	
Stress level (0-10)	
Wind-down activity	
Planned bedtime	

One thing on my mind tonight:

Day 4 • Morning sleep diary

Date of waking: _____

Sleep measure	Your estimate
Time I got into bed	
Time I tried to fall asleep	
Minutes until I fell asleep	
Number of nighttime awakenings	
Total minutes awake overnight	
Final wake-up time	
Time I got out of bed	
Estimated total sleep hours	
Sleep quality (1 very poor – 5 very good)	
Rested feeling (1 not rested – 5 very rested)	
Naps yesterday (time / duration)	

What may have helped or disturbed my sleep?

Day 5 • Evening check-in

Date: _____ Day of week: _____

Tonight's routine	Your notes
Caffeine today? Amount / last time	
Alcohol or nicotine today? (optional)	
Exercise / movement and timing	
Last meal or snack time	
Screen use in final hour before bed	
Stress level (0-10)	
Wind-down activity	
Planned bedtime	

One thing on my mind tonight:

Day 5 • Morning sleep diary

Date of waking: _____

Sleep measure	Your estimate
Time I got into bed	
Time I tried to fall asleep	
Minutes until I fell asleep	
Number of nighttime awakenings	
Total minutes awake overnight	
Final wake-up time	
Time I got out of bed	
Estimated total sleep hours	
Sleep quality (1 very poor – 5 very good)	
Rested feeling (1 not rested – 5 very rested)	
Naps yesterday (time / duration)	

What may have helped or disturbed my sleep?

Day 6 • Evening check-in

Date: _____ Day of week: _____

Tonight's routine	Your notes
Caffeine today? Amount / last time	
Alcohol or nicotine today? (optional)	
Exercise / movement and timing	
Last meal or snack time	
Screen use in final hour before bed	
Stress level (0-10)	
Wind-down activity	
Planned bedtime	

One thing on my mind tonight:

Day 6 • Morning sleep diary

Date of waking: _____

Sleep measure	Your estimate
Time I got into bed	
Time I tried to fall asleep	
Minutes until I fell asleep	
Number of nighttime awakenings	
Total minutes awake overnight	
Final wake-up time	
Time I got out of bed	
Estimated total sleep hours	
Sleep quality (1 very poor – 5 very good)	
Rested feeling (1 not rested – 5 very rested)	
Naps yesterday (time / duration)	

What may have helped or disturbed my sleep?

Day 7 • Evening check-in

Date: _____ Day of week: _____

Tonight's routine	Your notes
Caffeine today? Amount / last time	
Alcohol or nicotine today? (optional)	
Exercise / movement and timing	
Last meal or snack time	
Screen use in final hour before bed	
Stress level (0-10)	
Wind-down activity	
Planned bedtime	

One thing on my mind tonight:

Day 7 • Morning sleep diary

Date of waking: _____

Sleep measure	Your estimate
Time I got into bed	
Time I tried to fall asleep	
Minutes until I fell asleep	
Number of nighttime awakenings	
Total minutes awake overnight	
Final wake-up time	
Time I got out of bed	
Estimated total sleep hours	
Sleep quality (1 very poor – 5 very good)	
Rested feeling (1 not rested – 5 very rested)	
Naps yesterday (time / duration)	

What may have helped or disturbed my sleep?

Seven-day overview

Look for patterns rather than perfect numbers. Fill this table from your daily pages.

Day	Sleep hours	Quality 1-5	Rested 1-5	Notes
1				
2				
3				
4				
5				
6				
7				

What patterns did I notice in bedtime, wake time, and morning energy?

My next steps

Three habits that seemed helpful:

One small change I want to test next week:

Questions I want to ask a healthcare professional (if needed):

For persistent insomnia, evidence-based treatment such as cognitive behavioral therapy for insomnia (CBT-I) may be appropriate; discuss options with a qualified professional.

Bring this page to an appointment

A one-page summary you can complete and share with a healthcare professional.

Topic	Summary
My main concern	
How long it has been happening	
Typical bedtime and wake-up time	
Estimated sleep hours / range	
Nighttime awakenings	
Daytime sleepiness / functioning	
Snoring or observed breathing pauses (if known)	
Caffeine, alcohol, medication notes (optional)	

Other details or questions:

A calmer next week

Good sleep routines often include a consistent wake-up time, a comfortable sleep environment, and an evening wind-down. Your journal can help you discover which habits are realistic for you.

Small observations. Practical changes. Better-informed conversations.

Continue your journey at SleepHelpCenter.com

This resource is educational. It is not a substitute for medical evaluation, diagnosis, or treatment.