



Lab A7-7 Sleep

How Sleepy Are You?

To determine how drowsy you are during waking hours, record how likely you are to doze off in each of the following situations, using this scale:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

___ Sitting and reading

___ Watching television

___ Sitting passively in a public place (such as a theater or a meeting where you're not directly involved)

___ Being a passenger in a car for an hour

___ Lying down in the afternoon

___ Sitting and talking to someone

___ Sitting quietly after a lunch without alcohol

___ Sitting behind the wheel of a car while stopped for a few minutes in traffic

___ TOTAL

Scoring:

11–16 You may not get enough sleep or the quality of your sleep may be poor.

17 or more You may have a serious sleep disorder and may benefit from consulting a professional.

Strategies for Better Sleep

The following strategies can help you get a better night's sleep; check off any that you try:

___ Go to bed at the same time every night (time: _____), and get up at the same time every morning (time: _____).

___ Exercise daily, but not too close to bedtime.

___ Don't use tobacco.

___ Don't use caffeine in the late afternoon or evening.

___ Don't drink alcohol after dinner.

___ Eat a light snack before bedtime.

___ Write out a list of worries or a to-do list for the following day; then allow your mind to tune out such worries and distractions.

___ Don't eat, read, study, or watch television in bed.

___ Relax before bedtime with a book, music, or some relaxation exercises; give yourself time to wind down from your day's activities.

___ If you don't fall asleep in 15–20 minutes, get out of bed and do something monotonous until you feel sleepy. Do the same if you wake up and can't fall asleep again.

(over)

LAB A7-7 (continued)

Sleep Log

To help track your sleep behavior, keep a log similar to the following for several weeks. Look for patterns or lifestyle behaviors, such as caffeine use, that may interfere with sleep.

Date _____

Time you first turned out the lights last night: _____

How long it took you to fall asleep: _____

Number of times you awakened during the night: _____

Time you woke up for the last time this morning: _____

Total number of hours you slept last night: _____

How well did you sleep last night? (circle)

Terrible night 1 2 3 4 5 Great night

How rested did you feel this morning? (circle)

Not at all rested 1 2 3 4 5 Very well rested

How would you rate your overall mood and functioning during the day? (circle)

Poor 1 2 3 4 5 Very good

Additional notes

Caffeine use: _____

Tobacco use: _____

Alcohol use: _____

Exercise: _____

Sleeping medications: _____

Naps: _____

Stress level: _____

Other: _____