CORVALLIS
PAIN MANAGEMENT

Sleep and Pain Diary

NAME _____ Week of:_____

DAY	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
1. Did you nap? a. For how long? b. At what time?	Yes No _____min _____	Yes No _____min _____	Yes No _____min _____	Yes No _____min _____	Yes No _____min _____	Yes No _____min _____	Yes No _____min _____
2. Did you have any caffeine after 6pm?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
3. Did you drink alcohol after 6pm?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
4. Did you use nicotine after 6pm?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
5. Did you exercise?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
6. Did you eat a heavy meal or snack after 6pm?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
7. Did you take any sleeping medication a. What medication? b. Amount c. At what time?	Yes No _____ _____ _____	Yes No _____ _____ _____	Yes No _____ _____ _____	Yes No _____ _____ _____	Yes No _____ _____ _____	Yes No _____ _____ _____	Yes No _____ _____ _____
8. Were you sleepy during the day?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
NIGHT							
1. What time did you turn off the lights to go to sleep?							
2. What time did you wake up?							
3. How many total hours did you sleep?							
4. How many times did you wake up at night?							
5. Rate the quality of your sleep: 1=poor, 5=excellent							
6. Do you feel you got enough sleep?							

Date and time	Describe your pain	Rate Your Pain(0-10)	What made your pain worse?	What helped you get through the day?	Describe your activity level and mood	Other comments