

Division of Respiratory Medicine
Department of Pediatrics

Faculty of Medicine & Dentistry
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Dear Parent,

Enclosed is a Sleep Diary to be completed by you and your child. It should be completed for two weeks prior to your visit to the Pediatric Sleep Clinic or be completed for two weeks as instructed by your Sleep Specialist.

The purpose for completing this Diary is to provide information about your child's sleep patterns and habits in order to find the best way to help with their sleep problems.

If you have any questions or concerns in regards to the completion of this Sleep Diary, please contact the pediatric Sleep Coordinator at 780 407 2977 or via email at Rochelle.Young@albertahealthservices.ca.

Sincerely,

The Pediatric Sleep Medicine Team



STOLLERY
CHILDREN'S
HOSPITAL

_____ 's Sleep Diary

(Write your name here)

I am _____ years old and in _____ grade.

This is the week of _____, _____, _____.
(month) (date) (year)

1. Complete Before Going to Bed

• What did you drink today?

In the space under each can, write the number of cans/bottles of caffeinated drinks, like chocolate milk, pop and iced tea, you had each day of the week. Remember, caffeine is found in all kinds of drinks and can keep you from sleeping well.

WEEK ONE

Sunday



Monday



Tuesday



Wednesday



Thursday



Friday



Saturday



WEEK TWO

Sunday



Monday



Tuesday



Wednesday



Thursday



Friday



Saturday



2. Complete When You Wake UP

- **How did you sleep?**

Answer the first two questions by circling YES or NO. Write your answer to the last question.

WEEK ONE

	<u>Sunday</u>	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>	<u>Saturday</u>
Did you have trouble falling asleep?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Did you wake up during the night?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Who or what woke you up during the night?							

WEEK TWO

	<u>Sunday</u>	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>	<u>Saturday</u>
Did you have trouble falling asleep?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Did you wake up during the night?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Who or what woke you up during the night?							

**Stollery Children's Hospital
Child Sleep Diary Ages 5-11 Years**

• How much sleep did you get last night?

Color in the boxes from the time you fell asleep last night until the time you woke up in the morning. Count the number of boxes you colored in to figure out how many hours you slept. Write the number of hours you slept below each day.

<u>EXAMPLE</u>	<u>SUNDAY</u>	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>
7:00 PM	7:00 PM	7:00 PM	7:00 PM	7:00 PM	7:00 PM
7:30 PM	7:30 PM	7:30 PM	7:30 PM	7:30 PM	7:30 PM
8:00 PM	8:00 PM	8:00 PM	8:00 PM	8:00 PM	8:00 PM
8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM
9:00 PM	9:00 PM	9:00 PM	9:00 PM	9:00 PM	9:00 PM
9:30 PM	9:30 PM	9:30 PM	9:30 PM	9:30 PM	9:30 PM
10:00 PM	10:00 PM	10:00 PM	10:00 PM	10:00 PM	10:00 PM
10:30 PM	10:30 PM	10:30 PM	10:30 PM	10:30 PM	10:30 PM
11:00 PM	11:00 PM	11:00 PM	11:00 PM	11:00 PM	11:00 PM
11:30 PM	11:30 PM	11:30 PM	11:30 PM	11:30 PM	11:30 PM
12:00 AM	12:00 AM	12:00 AM	12:00 AM	12:00 AM	12:00 AM
12:30 AM	12:30 AM	12:30 AM	12:30 AM	12:30 AM	12:30 AM
1:00 AM	1:00 AM	1:00 AM	1:00 AM	1:00 AM	1:00 AM
1:30 AM	1:30 AM	1:30 AM	1:30 AM	1:30 AM	1:30 AM
2:00 AM	2:00 AM	2:00 AM	2:00 AM	2:00 AM	2:00 AM
2:30 AM	2:30 AM	2:30 AM	2:30 AM	2:30 AM	2:30 AM
3:00 AM	3:00 AM	3:00 AM	3:00 AM	3:00 AM	3:00 AM
3:30 AM	3:30 AM	3:30 AM	3:30 AM	3:30 AM	3:30 AM
4:00 AM	4:00 AM	4:00 AM	4:00 AM	4:00 AM	4:00 AM
4:30 AM	4:30 AM	4:30 AM	4:30 AM	4:30 AM	4:30 AM
5:00 AM	5:00 AM	5:00 AM	5:00 AM	5:00 AM	5:00 AM
5:30 AM	5:30 AM	5:30 AM	5:30 AM	5:30 AM	5:30 AM
6:00 AM	6:00 AM	6:00 AM	6:00 AM	6:00 AM	6:00 AM
6:30 AM	6:30 AM	6:30 AM	6:30 AM	6:30 AM	6:30 AM
7:00 AM	7:00 AM	7:00 AM	7:00 AM	7:00 AM	7:00 AM
7:30 AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM
8:00 AM	8:00 AM	8:00 AM	8:00 AM	8:00 AM	8:00 AM
8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM
9:00 AM	9:00 AM	9:00 AM	9:00 AM	9:00 AM	9:00 AM
9:30 AM	9:30 AM	9:30 AM	9:30 AM	9:30 AM	9:30 AM
10:00 AM	10:00 AM	10:00 AM	10:00 AM	10:00 AM	10:00 AM
10:30 AM	10:30 AM	10:30 AM	10:30 AM	10:30 AM	10:30 AM
I slept	I slept	I slept	I slept	I slept	I slept
11					
hours.	hours.	hours.	hours.	hours.	hours.

**Stollery Children's Hospital
Child Sleep Diary Ages 5-11 Years**

FRIDAY	SATURDAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY
7:00 PM	7:00 PM	7:00 PM	7:00 PM	7:00 PM	7:00 PM
7:30 PM	7:30 PM	7:30 PM	7:30 PM	7:30 PM	7:30 PM
8:00 PM	8:00 PM	8:00 PM	8:00 PM	8:00 PM	8:00 PM
8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM
9:00 PM	9:00 PM	9:00 PM	9:00 PM	9:00 PM	9:00 PM
9:30 PM	9:30 PM	9:30 PM	9:30 PM	9:30 PM	9:30 PM
10:00 PM	10:00 PM	10:00 PM	10:00 PM	10:00 PM	10:00 PM
10:30 PM	10:30 PM	10:30 PM	10:30 PM	10:30 PM	10:30 PM
11:00 PM	11:00 PM	11:00 PM	11:00 PM	11:00 PM	11:00 PM
11:30 PM	11:30 PM	11:30 PM	11:30 PM	11:30 PM	11:30 PM
12:00 AM	12:00 AM	12:00 AM	12:00 AM	12:00 AM	12:00 AM
12:30 AM	12:30 AM	12:30 AM	12:30 AM	12:30 AM	12:30 AM
1:00 AM	1:00 AM	1:00 AM	1:00 AM	1:00 AM	1:00 AM
1:30 AM	1:30 AM	1:30 AM	1:30 AM	1:30 AM	1:30 AM
2:00 AM	2:00 AM	2:00 AM	2:00 AM	2:00 AM	2:00 AM
2:30 AM	2:30 AM	2:30 AM	2:30 AM	2:30 AM	2:30 AM
3:00 AM	3:00 AM	3:00 AM	3:00 AM	3:00 AM	3:00 AM
3:30 AM	3:30 AM	3:30 AM	3:30 AM	3:30 AM	3:30 AM
4:00 AM	4:00 AM	4:00 AM	4:00 AM	4:00 AM	4:00 AM
4:30 AM	4:30 AM	4:30 AM	4:30 AM	4:30 AM	4:30 AM
5:00 AM	5:00 AM	5:00 AM	5:00 AM	5:00 AM	5:00 AM
5:30 AM	5:30 AM	5:30 AM	5:30 AM	5:30 AM	5:30 AM
6:00 AM	6:00 AM	6:00 AM	6:00 AM	6:00 AM	6:00 AM
6:30 AM	6:30 AM	6:30 AM	6:30 AM	6:30 AM	6:30 AM
7:00 AM	7:00 AM	7:00 AM	7:00 AM	7:00 AM	7:00 AM
7:30 AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM
8:00 AM	8:00 AM	8:00 AM	8:00 AM	8:00 AM	8:00 AM
8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM
9:00 AM	9:00 AM	9:00 AM	9:00 AM	9:00 AM	9:00 AM
9:30 AM	9:30 AM	9:30 AM	9:30 AM	9:30 AM	9:30 AM
10:00 AM	10:00 AM	10:00 AM	10:00 AM	10:00 AM	10:00 AM
10:30 AM	10:30 AM	10:30 AM	10:30 AM	10:30 AM	10:30 AM
I slept					

hours.					

**Stollery Children's Hospital
Child Sleep Diary Ages 5-11 Years**

THURSDAY

7:00 PM	<input type="checkbox"/>
7:30 PM	<input type="checkbox"/>
8:00 PM	<input type="checkbox"/>
8:30 PM	<input type="checkbox"/>
9:00 PM	<input type="checkbox"/>
9:30 PM	<input type="checkbox"/>
10:00 PM	<input type="checkbox"/>
10:30 PM	<input type="checkbox"/>
11:00 PM	<input type="checkbox"/>
11:30 PM	<input type="checkbox"/>
12:00 AM	<input type="checkbox"/>
12:30 AM	<input type="checkbox"/>
1:00 AM	<input type="checkbox"/>
1:30 AM	<input type="checkbox"/>
2:00 AM	<input type="checkbox"/>
2:30 AM	<input type="checkbox"/>
3:00 AM	<input type="checkbox"/>
3:30 AM	<input type="checkbox"/>
4:00 AM	<input type="checkbox"/>
4:30 AM	<input type="checkbox"/>
5:00 AM	<input type="checkbox"/>
5:30 AM	<input type="checkbox"/>
6:00 AM	<input type="checkbox"/>
6:30 AM	<input type="checkbox"/>
7:00 AM	<input type="checkbox"/>
7:30 AM	<input type="checkbox"/>
8:00 AM	<input type="checkbox"/>
8:30 AM	<input type="checkbox"/>
9:00 AM	<input type="checkbox"/>
9:30 AM	<input type="checkbox"/>
10:00 AM	<input type="checkbox"/>
10:30 AM	<input type="checkbox"/>

I slept

_____ **hours.**

FRIDAY

7:00 PM	<input type="checkbox"/>
7:30 PM	<input type="checkbox"/>
8:00 PM	<input type="checkbox"/>
8:30 PM	<input type="checkbox"/>
9:00 PM	<input type="checkbox"/>
9:30 PM	<input type="checkbox"/>
10:00 PM	<input type="checkbox"/>
10:30 PM	<input type="checkbox"/>
11:00 PM	<input type="checkbox"/>
11:30 PM	<input type="checkbox"/>
12:00 AM	<input type="checkbox"/>
12:30 AM	<input type="checkbox"/>
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1:30 AM	<input type="checkbox"/>
2:00 AM	<input type="checkbox"/>
2:30 AM	<input type="checkbox"/>
3:00 AM	<input type="checkbox"/>
3:30 AM	<input type="checkbox"/>
4:00 AM	<input type="checkbox"/>
4:30 AM	<input type="checkbox"/>
5:00 AM	<input type="checkbox"/>
5:30 AM	<input type="checkbox"/>
6:00 AM	<input type="checkbox"/>
6:30 AM	<input type="checkbox"/>
7:00 AM	<input type="checkbox"/>
7:30 AM	<input type="checkbox"/>
8:00 AM	<input type="checkbox"/>
8:30 AM	<input type="checkbox"/>
9:00 AM	<input type="checkbox"/>
9:30 AM	<input type="checkbox"/>
10:00 AM	<input type="checkbox"/>
10:30 AM	<input type="checkbox"/>

I slept

_____ **hours.**

SATURDAY

7:00 PM	<input type="checkbox"/>
7:30 PM	<input type="checkbox"/>
8:00 PM	<input type="checkbox"/>
8:30 PM	<input type="checkbox"/>
9:00 PM	<input type="checkbox"/>
9:30 PM	<input type="checkbox"/>
10:00 PM	<input type="checkbox"/>
10:30 PM	<input type="checkbox"/>
11:00 PM	<input type="checkbox"/>
11:30 PM	<input type="checkbox"/>
12:00 AM	<input type="checkbox"/>
12:30 AM	<input type="checkbox"/>
1:00 AM	<input type="checkbox"/>
1:30 AM	<input type="checkbox"/>
2:00 AM	<input type="checkbox"/>
2:30 AM	<input type="checkbox"/>
3:00 AM	<input type="checkbox"/>
3:30 AM	<input type="checkbox"/>
4:00 AM	<input type="checkbox"/>
4:30 AM	<input type="checkbox"/>
5:00 AM	<input type="checkbox"/>
5:30 AM	<input type="checkbox"/>
6:00 AM	<input type="checkbox"/>
6:30 AM	<input type="checkbox"/>
7:00 AM	<input type="checkbox"/>
7:30 AM	<input type="checkbox"/>
8:00 AM	<input type="checkbox"/>
8:30 AM	<input type="checkbox"/>
9:00 AM	<input type="checkbox"/>
9:30 AM	<input type="checkbox"/>
10:00 AM	<input type="checkbox"/>
10:30 AM	<input type="checkbox"/>

I slept

_____ **hours.**