

SLEEP DIARY

Today's date:	1/1/2015							
1a. How many times did you nap or doze?	2 times							
1b. In total, how long did you nap or doze?	1 hour							
2. What time did you get into bed?	10:15 p.m.							
3. What time did you try to go to sleep?	11:30 p.m.							
4. How long did it take you to fall asleep?	55 min.							
5. How many times did you wake up, not counting your final awakening?	6 times							
6. In total, how long did these awakenings last?	2 hours 5 min.							
7. What time was your final awakening?	6:35 a.m.							
8. What time did you get out of bed for the day?	7:20 a.m.							
9. In total, how long did you sleep?	4 hours 10 min.							
10. How would you rate the quality of your sleep?	<input type="checkbox"/> Very poor <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good
11. Did you have bad dreams or nightmares?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Number: 2 Time: N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No Number : Time:	<input type="checkbox"/> Yes <input type="checkbox"/> No Number: Time:	<input type="checkbox"/> Yes <input type="checkbox"/> No Number : Time:	<input type="checkbox"/> Yes <input type="checkbox"/> No Number : Time:	<input type="checkbox"/> Yes <input type="checkbox"/> No Number: Time:	<input type="checkbox"/> Yes <input type="checkbox"/> No Number : Time:	<input type="checkbox"/> Yes <input type="checkbox"/> No Number : Time:
12. Content:	I was chased by someone and could not run I was chased by the same person and strangled me							

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