BlueCross BlueShield of Vermont

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SleepWell® Tracker

Make enough copies for every day you are tracking your sleep.

		Date:	Date:	Date:	Date:	Date:	Date:	Date:
Complete in the morning	Time I went to bed							
	Time I got out of bed							
	I woke up during the night (# of times)							
	Total hours of sleep							
	What best describes the day today?	Work / Day Off / Vacation / School	Work / Day Off / Vacation / School	Work / Day Off / Vacation / School	Work / Day Off / Vacation / School	Work / Day Off / Vacation / School	Work / Day Off / Vacation / School	Work / Day Off / Vacation / School
	Energy upon waking 1 (Exhausted) – 5 (Refreshed)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
	My sleep was disturbed by (check all that apply)	☐ Noise ☐ Lights ☐ Partner in bed ☐ Temperature ☐ Bodily discomfort ☐ Illness or allergies ☐ Stress or worry	☐ Noise ☐ Lights ☐ Partner in bed ☐ Temperature ☐ Bodily discomfort ☐ Illness or allergies ☐ Stress or worry	☐ Noise ☐ Lights ☐ Partner in bed ☐ Temperature ☐ Bodily discomfort ☐ Illness or allergies ☐ Stress or worry	☐ Noise ☐ Lights ☐ Partner in bed ☐ Temperature ☐ Bodily discomfort ☐ Illness or allergies ☐ Stress or worry	☐ Noise ☐ Lights ☐ Partner in bed ☐ Temperature ☐ Bodily discomfort ☐ Illness or allergies ☐ Stress or worry	☐ Noise ☐ Lights ☐ Partner in bed ☐ Temperature ☐ Bodily discomfort ☐ Illness or allergies ☐ Stress or worry	☐ Noise ☐ Lights ☐ Partner in bed ☐ Temperature ☐ Bodily discomfort ☐ Illness or allergies ☐ Stress or worry
	Work shift (if applicable, e.g., night shift, 3rd shift)							
	Ate breakfast/ meal upon waking	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Complete in the evening	I consumed caffeine drinks (fill in # of cups)	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +	AM: 1 2 3 4 5 + PM: 1 2 3 4 5 +
	I exercised for at least 20 minutes	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	I napped today (if yes, record how long)	Yes: ________ No	Yes: ________ No	Yes: ________ No	Yes: ________ No	Yes: ________ No	Yes: ________ No	Yes: ________ No
	Level of daytime drowsiness (1 – no issues, 5 – very likely to doze off)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
	My mood throughout the day (circle or describe)	🙂 😐 ☹	🙂 😐 ☹	🙂 😐 ☹	🙂 😐 ☹	🙂 😐 ☹	🙂 😐 ☹	🙂 😐 ☹
	Activities in the hour before bedtime							