CHILD'S NAME: _____

PEDIATRIC SLEEP LOG

Please complete this sleep log for your child's previous day and night after he or she wakes up and gets out of bed in the morning. Please answer each item as best you can and bring the completed sleep log to your child's next appointment.

Day and Date	**Day of the Week:** **Date:**	**Day of the Week:** **Date:**	**Day of the Week:** **Date:**	**Day of the Week:** **Date:**	**Day of the Week:** **Date:**	**Day of the Week:** **Date:**	**Day of the Week:** **Date:**
About Your Child's Day							
Did your child take a nap today? For how long? At what time?	Yes□ No□ _____mins. _____	Yes□ No□ _____mins. _____	Yes□ No□ _____mins. _____	Yes□ No□ _____mins. _____	Yes□ No□ _____mins. _____	Yes□ No□ _____mins. _____	Yes□ No□ _____mins. _____
Were there any significant changes in your child's daytime routine today? If yes, please describe.	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□
Did your child seem over-tired or sleepy during the day?	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□
Did you have concerns about your child's mood and/or behavior? (e.g., irritability, over-activity, noncompliance?)	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□
Were there difficulties at school today (e.g., attention, work completion)?	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□
About Your Child's Night							
What time did your child get into bed?							
How long did it take your child to fall asleep?							
Did your child fall asleep independently? (e.g., without a parent present)	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□	Yes□ No□
How many times did your child wake up during the night?							
How long (in minutes) was your child awake during these awakenings?							
How many total hours did your child sleep last night?							
Other information about your child's night: (e.g., bedtime refusals, nightmares, bedwetting, significant changes in bedtime routine, medications)							