BULLETPROOF 30-DAY SLEEP CHALLENGE





Fill this out for the previous day and night, no more than 3 hours after waking. Use estimates when necessary..

WEEK OF:	
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DAY	SUN		MON		TUES		WED		THURS		FRI		SAT	
What time did you have caffeine?	Time:		Time:		Time:_		Time:		Time:		Time:		Time:	
Did you exercise?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Did you drink alcohol? When and how much?	Yes Amount:	No	Yes Amount:	No	Yes Amount	No :	Yes Amount:	No	Yes Amount	No ::	Yes Amoun	No t:	Yes Amount	No ::
Did you nap? If so, what time and for how long?	Yes Time:	No	Yes Time:	No	Yes Time:	No	Yes Time:	No	Yes Time:	No	Yes Time:	No	Yes Time:	No
When did you eat dinner?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Did you have a snack before bed?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Did you take any medication or supplements to help you sleep?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No ———
If so, which ones and at what time?	Time:		Time:		Time:_		Time:		Time:_		Time:		Time:	
Were you tired during the day?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
What was your mood like during the day?	Mood:		Mood:		Mood:_		Mood:_		Mood:_		Mood:_		Mood:_	

BULLETPROOF 30-DAY SLEEP CHALLENGE SLEEP LOG

NIGHT	SUN	SUN MON		WED	THURS	FRI	SAT
What time did you switch off the lights?	Time:						
Approximately how long did it take you to fall asleep?	Amount:						
How many times did you wake up during the night?	Amount:						
What time did you wake up?	Time:						
Rate the quality of your sleep: 5=deep rest; 1=poor	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
How did you feel when you woke up?	Mood:						