Pain Management Network

SLEEP DIARY

Name: ______________________________

Date: ______________________________

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
What time did you go to bed?							
What time did you go to sleep?							
What time did you wake up?							
Did you wake in the night?	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________
What caused you to wake?	☐Spasm ☐Snore/gasp ☐Bladder ☐________ ☐Pain ☐________	☐Spasm ☐Snore/gasp ☐Bladder ☐________ ☐Pain ☐________	☐Spasm ☐Snore/gasp ☐Bladder ☐________ ☐Pain ☐________	☐Spasm ☐Snore/gasp ☐Bladder ☐________ ☐Pain ☐________	☐Spasm ☐Snore/gasp ☐Bladder ☐________ ☐Pain ☐________	☐Spasm ☐Snore/gasp ☐Bladder ☐________ ☐Pain ☐________	☐Spasm ☐Snore/gasp ☐Bladder ☐________ ☐Pain ☐________
Was it hard to go back to sleep?	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________
Was alcohol consumed today?	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________
Was caffeine consumed today?	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________	☐Y ☐N ______________
Was exercise performed today?	☐Y ☐N ______________ ______________	☐Y ☐N ______________ ______________	☐Y ☐N ______________ ______________	☐Y ☐N ______________ ______________	☐Y ☐N ______________ ______________	☐Y ☐N ______________ ______________	☐Y ☐N ______________ ______________
What medications do you use?							

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Date: _____

Pain intensity & interference:

In general, how much has pain interfered with your day-to-day **activities** in the last week?*	1 2 3 4 5 6 7 8 9 10 *(where 0 = no interference and 10 = extreme interference)*
In general, how much has pain interfered with your overall **mood** in the last week? *	1 2 3 4 5 6 7 8 9 10 *(where 0 = no interference and 10 = extreme interference)*
In general, how much has pain interfered with your ability to get a good night's **sleep**? *	1 2 3 4 5 6 7 8 9 10 *(where 0 = no interference and 10 = extreme interference)*
Average pain **intensity** in the past week?	0 1 2 3 4 5 6 7 8 9 10 *(where 0 = no pain and 10 = pain as bad as you can imagine)*

**Questions marked with an * are from the International Spinal Cord Injury Pain Basic Data Set: Version 2 (Widerstrom-Noga et al 2014)*

Screening for Obstructive Sleep Apnoea

How many days per week do you?

Snore, snort or gasp?	0	1	2	3	4	5	6	7
Wake up frequently during the night?	0	1	2	3	4	5	6	7
Have problems with daytime drowsiness?	0	1	2	3	4	5	6	7
Have problems with short term memory?	0	1	2	3	4	5	6	7
Have problems with daytime concentration?	0	1	2	3	4	5	6	7
Experience morning headaches?	0	1	2	3	4	5	6	7

If you frequently experience snoring, gasping, frequent awakenings at night and/or problems with daytime drowsiness, short term memory, concentration or morning headaches you may have symptoms of obstructive sleep apnoea. A simple test can confirm if you have this condition and treatment is available. Speak with your GP, case manager, rehabilitation specialist, physiotherapist or nurse for details of resources in your local area.