SLEEP QUALITY TRACKER

Completing the symptom tracker each week allows you and your Practitioner to monitor your response to treatment and assess your sleep quality.

Metagenics
Genetic Potential Through Nutrition

	WEEK 1							WEEK 2						
	S	M	T	W	T	F	S	S	M	T	W	T	F	S
FACTORS THAT AFFECT SLEEP: Fill out before bed (Y/N)														
Did you consume caffeine today? If so, indicate quantity and timing (e.g. 1 espresso 2 pm).														
Did you consume alcohol today? If so, indicate quantity (e.g. 1 glass of wine).														
Did you use an electronic device before bed (i.e. TV, tablet or phone)?														
Did you work a night shift?														
Did you take any sleep medications before bed?														
Other:														
SLEEP CYCLE INFORMATION: Fill out daily														
What time did you last eat/drink (i.e. 7.30 pm)?														
What time did you go to bed (i.e. 10:30 pm)?														
How long did it take you to fall asleep (i.e. < 20 minutes)?														
How often did you wake up during the night (i.e. 1 to 2)?														
How long were you awake during the night (i.e. 45 minutes)?														
What time did you wake up (i.e. 5.00 am)?														
What time did you get out of bed (i.e. 6.00 am)?														
Total hours of sleep:														
SLEEP QUALITY SCORES: Rate the following areas using a scale of 1 to 5 (1-Very Poor , 2-Poor, 3-Fair, 4-Good, 5-Very Good)														
Did you wake feeling refreshed?														
How would you rate your sleep quality?														
Rate your energy levels throughout the day.														
SUPPLEMENTS: Fill out daily (Y/N)														
Did you take your supplements today?														

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	WEEK 3							WEEK 4						
	S	M	T	W	T	F	S	S	M	T	W	T	F	S
FACTORS THAT AFFECT SLEEP: Fill out before bed (Y/N)														
Did you consume caffeine today? If so, indicate quantity and timing (e.g. 1 espresso 2 pm).														
Did you consume alcohol today? If so, indicate quantity (e.g. 1 glass of wine).														
Did you use an electronic device before bed (i.e. TV, tablet or phone)?														
Did you work a night shift?														
Did you take any sleep medications before bed?														
Other:														
SLEEP CYCLE INFORMATION: Fill out daily														
What time did you last eat/drink (i.e. 7.30 pm)?														
What time did you go to bed (i.e. 10:30 pm)?														
How long did it take you to fall asleep (i.e. < 20 minutes)?														
How often did you wake up during the night (i.e. 1 to 2)?														
How long were you awake during the night (i.e. 45 minutes)?														
What time did you wake up (i.e. 5.00 am)?														
What time did you get out of bed (i.e. 6.00 am)?														
Total hours of sleep:														
SLEEP QUALITY SCORES: Rate the following areas using a scale of 1 to 5 (1-Very Poor , 2-Poor, 3-Fair, 4-Good, 5-Very Good)														
Did you wake feeling refreshed?														
How would you rate your sleep quality?														
Rate your energy levels throughout the day.														
SUPPLEMENTS: Fill out daily (Y/N)														
Did you take your supplements today?														

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