

# SLEEP PLAN PRACTICAL GUIDE

breathing  
space  
HEALTH



VISIT [BREATHINGSPACEHEALTH.COM.AU](https://breathingspacehealth.com.au)

Breathing Space Health™ programs are intended to assist individuals seeking self-improvement and personal understanding of common issues related to sleep behaviours and non-clinical sleep conditions. It is not intended to describe sleep disorders, assist those individuals that may have clinically-disordered sleep or sleep disorders, or who participate in shift work.

Please talk with your doctor or specialist about your questions and concerns regarding sleep disorders, sleep-related illnesses or other medical concerns.

Sufficient sleep is important for your health, wellbeing and performance. When you sleep better, you feel better.

To improve your sleep fitness we will begin the process of developing your sleep plan. Many of us will have implemented a diet plan, or an exercise program in the past, but how many of us have created a personalised sleep plan with the intention to feel healthier and sharpen performance?

Those who are able to look at their sleep systematically, determine the factors contributing to their problem, and tackle these things with a proactive plan that makes sense to the individual can be very successful at overcoming sleep problems.

**MAKE SLEEP YOUR PRIORITY TODAY.**

## PRE ASSESSMENT: SLEEP HYGIENE INDEX

#	QUESTION
1	I take daytime naps lasting two or more hours
2	I go to bed at different times from day to day
3	I get out of bed at different times from day to day
4	I exercise to the point of sweating within 1 hour of going to bed
5	I stay in bed longer than I should two or three times a week
6	I use alcohol, caffeine or tobacco within 4 hours of going to bed or after going to bed
7	I do something that may wake me up before bedtime (for example: play video games, use the internet or clean)
8	I go to bed feeling stressed, angry, upset or nervous
9	I use my bed for things other than sleeping (for example: watch television, read, eat or study)
10	I sleep on an uncomfortable bed (for example: poor mattress or pillow, too many or not enough blankets)
11	I sleep in an uncomfortable bedroom (for example: too bright, too stuffy, too hot, too cold or too noisy)
12	I do important work before bedtime (for example: pay bills, read documents or study)
13	I think, plan or worry when I'm in bed

ALWAYS	FREQUENTLY	SOMETIMES	RARELY	NEVER

MY SLEEP PLAN

BASAL SLEEP NEED (HOURS)	
WAKE UP TIME GOAL	
SLEEP TIME GOAL	
OBSTACLES	

PRE-SLEEP ROUTINE START TIME		
RELAXING ACTIVITIES TO ENJOY		
STRESS RELATED ACTIVITIES TO AVOID		
OBSTACLES		

ITEMS CONSUMED	CEASE TIME	LIMIT
CAFFEINATED BEVERAGES		
FOODS TO AVOID WITHIN 3 HOURS OF BEDTIME		
MEDICATIONS TO CONSIDER		

NOTES & OTHER OBSERVATIONS:



BEDROOM EVALUATION

ITEM	POSITIVE	NEGATIVE	NEUTRAL	MODIFICATION
LIGHT				
NOISE				
TEMPERATURE				
VENTILATION				
MATTRESS				
PILLOWS/ COVERS				
TELEVISION				
COMPUTERS/ TECHNOLOGY				
FAMILY				
SNORING				
PETS				
BREATHING				

NOTES & OTHER OBSERVATIONS:



## MY EXERCISE PLAN

### MONDAY

TYPE OF EXERCISE	START TIME	DURATION	INTENSITY (LOW,MED,HIGH)

### TUESDAY

TYPE OF EXERCISE	START TIME	DURATION	INTENSITY (LOW,MED,HIGH)

### WEDNESDAY

TYPE OF EXERCISE	START TIME	DURATION	INTENSITY (LOW,MED,HIGH)

### THURSDAY

TYPE OF EXERCISE	START TIME	DURATION	INTENSITY (LOW,MED,HIGH)

### FRIDAY

TYPE OF EXERCISE	START TIME	DURATION	INTENSITY (LOW,MED,HIGH)

### SATURDAY

TYPE OF EXERCISE	START TIME	DURATION	INTENSITY (LOW,MED,HIGH)

### SUNDAY

TYPE OF EXERCISE	START TIME	DURATION	INTENSITY (LOW,MED,HIGH)

## SLEEP DIARY

Sufficient sleep is important for your health, wellbeing and performance. When you sleep better, you feel better.

The Breathing Space Health Sleep Diary will help you track your sleep, allowing you to see habits and trends that are helping you sleep or that can be improved.

### How to Use the Breathing Space Health Sleep Diary

- The sleep diary only takes a few minutes to complete each day.
- There are diary entries for seven days. You may need to make several copies.
- Review your completed diary to see if there are any patterns or practices that are helping or hindering your sleep. Is your bedroom a sanctuary for sleep? Or are there too many distractions? Did your nap interfere with a good night's sleep?
- Make incremental changes. Changing one habit at a time can set you on the path to healthy sleep.

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## SLEEP DIARY: COMPLETE IN THE MORNING

START DATE: ___/___/___	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Day of the Week:							
I went to bed last night at:	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM
I got out of bed this morning at:	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
Last night I feel asleep:							
Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After some time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I woke up during the night:							
# of times							
# of minutes							
Last night I slept a total of:	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS
My sleep was disturbed by: <i>List mental or physical factors including noise, lights, pets, allergies, temperature, discomfort, stress etc.</i>							
When I woke up for the day, I felt:							
Refreshed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somewhat Refreshed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NOTES:							

## SLEEP DIARY: COMPLETE IN THE EVENING

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Day of the Week:							
I consumed caffeinated drinks in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
M / A / E / NA							
How many?							
I exercised at least 20 minutes in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
M / A / E / NA							
How much?							
Medications I took today:							
Took a nap?							
Yes/No							
During the day, how likely was I to doze off while in class or at school: No chance (NC), Slight chance (SL), Moderate chance (MC), High chance (HC)							
NC / SL / MC / HG							
Throughout the day, my mood was ... (Very pleasant (VP), Pleasant (P), Unpleasant (U), Very unpleasant (VU))							
VP / P / U / VU							
Approximately 2-3 hours before going to bed, I consumed:							
A heavy meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the hour before going to bed, my bedtime routine included: <i>List activities including reading a book, using electronics, taking a bath, doing relaxation exercises, etc.</i>							

NOTES & OTHER OBSERVATIONS:

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