PATIENT NAME: ______________________

START DATE: __________ **END DATE:** __________ Next session: __________ at ______ AM PM

Fatigue Rating Scale	0	25	50	75	100
	Extremely fatigued	Moderately fatigued	Mildly fatigued	Somewhat energetic	Very energetic

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
☀	Date															
☀	Sleep meds or alcohol (name and dose)															
☀	Time you went to bed															
☀	How long it took you to fall asleep for the first time															
☀	Number of times you woke up after asleep															
☀	How long you were awake during the night															
☀	Time you woke up this morning for the last time															
☾	Fatigue rating															
☾	Naps (start and end times)															
☾	Time you felt most alert															

☀ **COMPLETE IN MORNING** in reference to previous night

☾ **COMPLETE AT NIGHT** in reference to today

Notes: