



Sleep Well:

Your Personal Sleep Tracker

Enhance Your Sleep Quality: Discover Patterns, Understand Influences, and Elevate Your Sleep Hygiene.

Sleep Well is a pillar of TheKey's Balanced Care Method™:
A proprietary approach to whole person care for well-being of mind, body, and spirit.

¹ Min, Y., & Slattum, P. W. (2018). Poor sleep and risk of falls in community-dwelling older adults: A systematic review. *Journal of Applied Gerontology*, 37(9), 1059-1084.

² Yaffe, K., Falvey, C. M., & Hoang, T. (2014). Connections between sleep and cognition in older adults. *The Lancet Neurology*, 13(10), 1017-1028.

³ Fang, H., Tu, S., Sheng, J., & Shao, A. (2019). Depression in sleep disturbance: a review on a bidirectional relationship, mechanisms and treatment. *Journal of cellular and molecular medicine*, 23(4), 2324-2332.





Older adults typically have the same sleep needs as younger adults (generally, 7-9 hours per night), but they tend to have more disrupted sleep.

Poor sleep in older adults is associated with a greater risk of falls, cognitive decline, and depressive symptoms. Evidence-based sleep hygiene practices, such as consistent sleep and wake times, increasing overall light exposure, and limiting caffeine, can improve sleep quality. Additionally, tracking not just sleep duration but also behaviors that influence sleep quality can provide valuable insights into improving overall sleep health and well-being. Sharing this information with your doctor can assist them in better understanding any concerns about your sleep and help tailor appropriate interventions.



Sleep Well:

Your Personal Sleep Tracker

Please complete the following:

- What is your ideal time asleep? _____
- What is your ideal time awake? _____
- How much do you hope to exercise on average each day? _____ (min)
- What goals do you have for your sleep? *(Select all that apply)*
 - Sleep earlier
 - Sleep later
 - Wake up earlier
 - Sleep later
 - More energy during the day
 - Feel more rested during the day
 - Fewer/shorter naps
 - Other _____

Complete in the morning.		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
WAKE-UP TIME	What time did you wake up?	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
RESTFULNESS	How rested and refreshed do you feel this morning from 1 to 10.	1- Not Rested — 10- Extremely Rested						
TIME TO BED	What time did you get into bed?	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
TIME ASLEEP	What time did you actually fall asleep?	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
NIGHT WAKINGS	How many times did you wake up during the night?							
TIME AWAKE	How long were you awake during the night?							
TOTAL SLEEP TIME	Last night I slept a total of:	Hours Minutes	Hours Minutes	Hours Minutes	Hours Minutes	Hours Minutes	Hours Minutes	Hours Minutes
SLEEP QUALITY	How would you rate your sleep quality from 1 to 10.	1- Extremely Poor — 10- Extremely Excellent						
INTENTIONS FOR THE DAY	What are you hoping to do today?							

Complete in the evening.		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
CAFFEINE	When did you last have caffeine?	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
NAPS	Did you take a nap today? If yes, for how long?	Yes No Minutes:	Yes No Minutes:	Yes No Minutes:	Yes No Minutes:	Yes No Minutes:	Yes No Minutes:	Yes No Minutes:
EXERCISE	How many minutes did you exercise today?	Minutes:	Minutes:	Minutes:	Minutes:	Minutes:	Minutes:	Minutes:
EXERCISE TYPE	If you did exercise, what did you do?							
SLEEP AIDS	List any medications or supplements you took before bed (e.g., melatonin)							
INTENTIONS	Were you able to meet the goals you had for the day?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
ENERGY LEVEL	How would you rate your energy level on average during the day?	1- Extremely Low Energy (tired, lethargic, unable to focus) — 10- Extremely High Energy (vibrant, alert, enthusiastic)						
SLEEP HABITS	2-3 hours before bed, I consumed...	<input type="checkbox"/> Caffeine <input type="checkbox"/> Heavy meal <input type="checkbox"/> Alcohol <input type="checkbox"/> > 1 glass liquid <input type="checkbox"/> None of these	<input type="checkbox"/> Caffeine <input type="checkbox"/> Heavy meal <input type="checkbox"/> Alcohol <input type="checkbox"/> > 1 glass liquid <input type="checkbox"/> None of these	<input type="checkbox"/> Caffeine <input type="checkbox"/> Heavy meal <input type="checkbox"/> Alcohol <input type="checkbox"/> > 1 glass liquid <input type="checkbox"/> None of these	<input type="checkbox"/> Caffeine <input type="checkbox"/> Heavy meal <input type="checkbox"/> Alcohol <input type="checkbox"/> > 1 glass liquid <input type="checkbox"/> None of these	<input type="checkbox"/> Caffeine <input type="checkbox"/> Heavy meal <input type="checkbox"/> Alcohol <input type="checkbox"/> > 1 glass liquid <input type="checkbox"/> None of these	<input type="checkbox"/> Caffeine <input type="checkbox"/> Heavy meal <input type="checkbox"/> Alcohol <input type="checkbox"/> > 1 glass liquid <input type="checkbox"/> None of these	<input type="checkbox"/> Caffeine <input type="checkbox"/> Heavy meal <input type="checkbox"/> Alcohol <input type="checkbox"/> > 1 glass liquid <input type="checkbox"/> None of these
NIGHTTIME ROUTINE	What will you do to wind down for bed? <i>(e.g., watch tv, use laptop, read a book, listen to music)</i>							
SLEEP MOOD	How would you describe your mood before bed?	<input type="checkbox"/> Relaxed <input type="checkbox"/> Anxious <input type="checkbox"/> Worried <input type="checkbox"/> Content <input type="checkbox"/> Other	<input type="checkbox"/> Relaxed <input type="checkbox"/> Anxious <input type="checkbox"/> Worried <input type="checkbox"/> Content <input type="checkbox"/> Other	<input type="checkbox"/> Relaxed <input type="checkbox"/> Anxious <input type="checkbox"/> Worried <input type="checkbox"/> Content <input type="checkbox"/> Other	<input type="checkbox"/> Relaxed <input type="checkbox"/> Anxious <input type="checkbox"/> Worried <input type="checkbox"/> Content <input type="checkbox"/> Other	<input type="checkbox"/> Relaxed <input type="checkbox"/> Anxious <input type="checkbox"/> Worried <input type="checkbox"/> Content <input type="checkbox"/> Other	<input type="checkbox"/> Relaxed <input type="checkbox"/> Anxious <input type="checkbox"/> Worried <input type="checkbox"/> Content <input type="checkbox"/> Other	<input type="checkbox"/> Relaxed <input type="checkbox"/> Anxious <input type="checkbox"/> Worried <input type="checkbox"/> Content <input type="checkbox"/> Other
PAIN	What is your pain level? <i>(Pain level from 0 to 10)</i>	0- No Pain — 10- Severe Pain						