CBT for Sleep Worksheet

Name: **Age:**

Date range:

This worksheet is designed to help patients undergoing Cognitive Behavioral Therapy for Insomnia (CBT-I). It aims to identify and modify thoughts and behaviors that contribute to sleep disturbances.

Tips for improving sleep
Stimulus **Control:** • Use the bed only for sleep and intimacy. Avoid other activities such as reading, watching TV, or using your phone. • If unable to sleep within 20 minutes, get out of bed and do a relaxing activity until you feel sleepy.
Sleep Restriction • Based on your sleep diary, calculate your average total sleep time. • Set a fixed wake-up time and adjust your bedtime to ensure a sleep window that matches your average sleep time. • **Gradually increase your time in bed as your sleep efficiency improves.**
Relaxation Techniques Practice relaxation techniques to help you wind down before bed: • Deep breathing exercises • Progressive muscle relaxation • **Visualization or guided imagery**
Sleep Hygiene • Maintain a regular sleep schedule. • Create a comfortable sleep environment. • Limit caffeine and alcohol intake. • Avoid heavy meals close to bedtime. • **Get regular exercise, but not close to bedtime.**

Weekly Goals

Set specific goals for the upcoming week.

Goal 1:

Goal 2:

Goal 3:

Cognitive Restructuring

Identify negative thoughts that may be affecting your sleep.

What evidence supports these negative thoughts?

What evidence disproves these thoughts?

Create an alternative, more balanced thought after considering the evidence.

Sleep Diary: Night 1

For the next week, record the following details each morning.

Date:	Time spent awake during the night:
Time you went to bed:	Time you woke up:
Time you fell asleep:	Time you got out of bed:
Number of awakenings during the night:	Quality of sleep (1-10):

Comments/Notes:

Sleep Diary: Night 2

For the next week, record the following details each morning.

Date:	Time spent awake during the night:
Time you went to bed:	Time you woke up:
Time you fell asleep:	Time you got out of bed:
Number of awakenings during the night:	Quality of sleep (1-10):

Comments/Notes:

Sleep Diary: Night 3

For the next week, record the following details each morning.

Date:	Time spent awake during the night:
Time you went to bed:	Time you woke up:
Time you fell asleep:	Time you got out of bed:
Number of awakenings during the night:	Quality of sleep (1-10):

Comments/Notes:

Sleep Diary: Night 4

For the next week, record the following details each morning.

Date:	Time spent awake during the night:
Time you went to bed:	Time you woke up:
Time you fell asleep:	Time you got out of bed:
Number of awakenings during the night:	Quality of sleep (1-10):

Comments/Notes:

Sleep Diary: Night 5

For the next week, record the following details each morning.

Date:	Time spent awake during the night:
Time you went to bed:	Time you woke up:
Time you fell asleep:	Time you got out of bed:
Number of awakenings during the night:	Quality of sleep (1-10):

Comments/Notes:

Sleep Diary: Night 6

For the next week, record the following details each morning.

Date:	Time spent awake during the night:
Time you went to bed:	Time you woke up:
Time you fell asleep:	Time you got out of bed:
Number of awakenings during the night:	Quality of sleep (1-10):

Comments/Notes:

Sleep Diary: Night 7

For the next week, record the following details each morning.

Date:	Time spent awake during the night:
Time you went to bed:	Time you woke up:
Time you fell asleep:	Time you got out of bed:
Number of awakenings during the night:	Quality of sleep (1-10):

Comments/Notes:

Healthcare Professional's Additional Notes and Recommendations