





# 3. Fatigue diary (fill in before going to bed)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 6	
Date								
Number of caffeine drinks I consumed in the (M)orning, (A)fternoon, (E)vening	M A E N/A	M A E N/A	M A E N/A	M A E N/A	M A E N/A	M A E N/A	M A E N/A	
I exercise at least 20 mins in the (M)orning, (A)fternoon, (E)vening, N/A	M A E N/A	M A E N/A	M A E N/A	M A E N/A	M A E N/A	M A E N/A	M A E N/A	
Medications I took today								
Took a nap (circle one)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	
Nap time								
While performing daily activities, how many times if any, did I doze off								
Throughout the day my mood was...	Very pleasant <input type="checkbox"/> Pleasant <input type="checkbox"/> Unpleasant <input type="checkbox"/> Very unpleasant <input type="checkbox"/>	Very pleasant <input type="checkbox"/> Pleasant <input type="checkbox"/> Unpleasant <input type="checkbox"/> Very unpleasant <input type="checkbox"/>	Very pleasant <input type="checkbox"/> Pleasant <input type="checkbox"/> Unpleasant <input type="checkbox"/> Very unpleasant <input type="checkbox"/>	Very pleasant <input type="checkbox"/> Pleasant <input type="checkbox"/> Unpleasant <input type="checkbox"/> Very unpleasant <input type="checkbox"/>	Very pleasant <input type="checkbox"/> Pleasant <input type="checkbox"/> Unpleasant <input type="checkbox"/> Very unpleasant <input type="checkbox"/>	Very pleasant <input type="checkbox"/> Pleasant <input type="checkbox"/> Unpleasant <input type="checkbox"/> Very unpleasant <input type="checkbox"/>	Very pleasant <input type="checkbox"/> Pleasant <input type="checkbox"/> Unpleasant <input type="checkbox"/> Very unpleasant <input type="checkbox"/>	Very pleasant <input type="checkbox"/> Pleasant <input type="checkbox"/> Unpleasant <input type="checkbox"/> Very unpleasant <input type="checkbox"/>
In the hour before going to sleep my routine included (see tool box)								

