

A symptom diary is a helpful tool when working with your health care professional to assess your sleep habits and to identify or manage RLS. Write in your RLS Symptom Diary each day to keep track of your sleep habits and RLS symptoms. It's a good idea to fill out your RLS Symptom Diary after waking up for the day and before going to bed. It should only take you a few minutes to complete. You can even make copies to use for additional weeks.

After writing in your RLS Symptom Diary for about two weeks, you may begin to see patterns or recognize triggers that affect your sleep and RLS symptoms. Be sure to review and discuss these with your health care professional. To help you do this, fill out the RLS Symptom Diary Summary and share it with your health care professional. He or she can quickly and easily review your sleep habits and RLS symptoms.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Today's date:							
Which symptoms did I experience today? <i>(check all that apply)</i>	<input type="checkbox"/> painful <input type="checkbox"/> creeping <input type="checkbox"/> crawling <input type="checkbox"/> aching <input type="checkbox"/> pulling <input type="checkbox"/> tugging <input type="checkbox"/> pins & needles <input type="checkbox"/> itchy bones	<input type="checkbox"/> painful <input type="checkbox"/> creeping <input type="checkbox"/> crawling <input type="checkbox"/> aching <input type="checkbox"/> pulling <input type="checkbox"/> tugging <input type="checkbox"/> pins & needles <input type="checkbox"/> itchy bones	<input type="checkbox"/> painful <input type="checkbox"/> creeping <input type="checkbox"/> crawling <input type="checkbox"/> aching <input type="checkbox"/> pulling <input type="checkbox"/> tugging <input type="checkbox"/> pins & needles <input type="checkbox"/> itchy bones	<input type="checkbox"/> painful <input type="checkbox"/> creeping <input type="checkbox"/> crawling <input type="checkbox"/> aching <input type="checkbox"/> pulling <input type="checkbox"/> tugging <input type="checkbox"/> pins & needles <input type="checkbox"/> itchy bones	<input type="checkbox"/> painful <input type="checkbox"/> creeping <input type="checkbox"/> crawling <input type="checkbox"/> aching <input type="checkbox"/> pulling <input type="checkbox"/> tugging <input type="checkbox"/> pins & needles <input type="checkbox"/> itchy bones	<input type="checkbox"/> painful <input type="checkbox"/> creeping <input type="checkbox"/> crawling <input type="checkbox"/> aching <input type="checkbox"/> pulling <input type="checkbox"/> tugging <input type="checkbox"/> pins & needles <input type="checkbox"/> itchy bones	<input type="checkbox"/> painful <input type="checkbox"/> creeping <input type="checkbox"/> crawling <input type="checkbox"/> aching <input type="checkbox"/> pulling <input type="checkbox"/> tugging <input type="checkbox"/> pins & needles <input type="checkbox"/> itchy bones
Today, I experienced my RLS symptoms at what time(s)?	<input type="checkbox"/> early morning <input type="checkbox"/> mid morning <input type="checkbox"/> mid day <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> night <input type="checkbox"/> late night	<input type="checkbox"/> early morning <input type="checkbox"/> mid morning <input type="checkbox"/> mid day <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> night <input type="checkbox"/> late night	<input type="checkbox"/> early morning <input type="checkbox"/> mid morning <input type="checkbox"/> mid day <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> night <input type="checkbox"/> late night	<input type="checkbox"/> early morning <input type="checkbox"/> mid morning <input type="checkbox"/> mid day <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> night <input type="checkbox"/> late night	<input type="checkbox"/> early morning <input type="checkbox"/> mid morning <input type="checkbox"/> mid day <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> night <input type="checkbox"/> late night	<input type="checkbox"/> early morning <input type="checkbox"/> mid morning <input type="checkbox"/> mid day <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> night <input type="checkbox"/> late night	<input type="checkbox"/> early morning <input type="checkbox"/> mid morning <input type="checkbox"/> mid day <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> night <input type="checkbox"/> late night
My symptoms got worse or more frequent in the evening?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
I slept how many hours last night?	<input type="checkbox"/> less than 2 <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 4 <input type="checkbox"/> 8+	<input type="checkbox"/> less than 2 <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 4 <input type="checkbox"/> 8+	<input type="checkbox"/> less than 2 <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 4 <input type="checkbox"/> 8+	<input type="checkbox"/> less than 2 <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 4 <input type="checkbox"/> 8+	<input type="checkbox"/> less than 2 <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 4 <input type="checkbox"/> 8+	<input type="checkbox"/> less than 2 <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 4 <input type="checkbox"/> 8+	<input type="checkbox"/> less than 2 <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 4 <input type="checkbox"/> 8+
I exercised how long today?	<input type="checkbox"/> 0-15 mins <input type="checkbox"/> 30-60 mins <input type="checkbox"/> 15-30 mins <input type="checkbox"/> 60 mins+	<input type="checkbox"/> 0-15 mins <input type="checkbox"/> 30-60 mins <input type="checkbox"/> 15-30 mins <input type="checkbox"/> 60 mins+	<input type="checkbox"/> 0-15 mins <input type="checkbox"/> 30-60 mins <input type="checkbox"/> 15-30 mins <input type="checkbox"/> 60 mins+	<input type="checkbox"/> 0-15 mins <input type="checkbox"/> 30-60 mins <input type="checkbox"/> 15-30 mins <input type="checkbox"/> 60 mins+	<input type="checkbox"/> 0-15 mins <input type="checkbox"/> 30-60 mins <input type="checkbox"/> 15-30 mins <input type="checkbox"/> 60 mins+	<input type="checkbox"/> 0-15 mins <input type="checkbox"/> 30-60 mins <input type="checkbox"/> 15-30 mins <input type="checkbox"/> 60 mins+	<input type="checkbox"/> 0-15 mins <input type="checkbox"/> 30-60 mins <input type="checkbox"/> 15-30 mins <input type="checkbox"/> 60 mins+
My symptoms improved when I moved around?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Did I consume any of these substances today? <i>(Include the time that you consumed each)</i>	<input type="checkbox"/> Caffeine time: <input type="checkbox"/> Alcohol time: <input type="checkbox"/> Tobacco products time: <input type="checkbox"/> Over the counter medication/prescription time:	<input type="checkbox"/> Caffeine time: <input type="checkbox"/> Alcohol time: <input type="checkbox"/> Tobacco products time: <input type="checkbox"/> Over the counter medication/prescription time:	<input type="checkbox"/> Caffeine time: <input type="checkbox"/> Alcohol time: <input type="checkbox"/> Tobacco products time: <input type="checkbox"/> Over the counter medication/prescription time:	<input type="checkbox"/> Caffeine time: <input type="checkbox"/> Alcohol time: <input type="checkbox"/> Tobacco products time: <input type="checkbox"/> Over the counter medication/prescription time:	<input type="checkbox"/> Caffeine time: <input type="checkbox"/> Alcohol time: <input type="checkbox"/> Tobacco products time: <input type="checkbox"/> Over the counter medication/prescription time:	<input type="checkbox"/> Caffeine time: <input type="checkbox"/> Alcohol time: <input type="checkbox"/> Tobacco products time: <input type="checkbox"/> Over the counter medication/prescription time:	<input type="checkbox"/> Caffeine time: <input type="checkbox"/> Alcohol time: <input type="checkbox"/> Tobacco products time: <input type="checkbox"/> Over the counter medication/prescription time:
On a scale from 1 to 5 (with 5 being the worst) my symptoms were how severe?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5