

## **RLS Symptom Diary**

The RLS Symptom Diary is a tool to track your daily activities, RLS symptoms and sleep patterns.

- Use the table on the back of this page to keep a diary for two weeks.
- Once you have completed the diary, then complete this page, which summarizes the information you've collected.
- After completing both pages, review them with your healthcare provider to help identify patterns or triggers that may contribute to sleepless nights and RLS symptoms.

Name: Today's Date:
1) Number of days I completed my RLS Symptom Diary:
$\Box$ 1 day $\Box$ 2-3 days $\Box$ 4-7 days $\Box$ 1-2 weeks $\Box$ 2+ weeks
2) The RLS symptoms I recorded most frequently can best be described as (check all that apply):
□ painful □ creeping □ crawling □ aching □ pulling □ tugging □ pins & needles □ other
3) On average, I experienced my symptoms at what time(s) each day:
$\square$ early morning $\square$ midmorning $\square$ midday $\square$ afternoon $\square$ evening $\square$ night $\square$ late night
4) On average, I slept how many hours each night:
$\square$ less than 2 $\square$ 2 $\square$ 3 $\square$ 4 $\square$ 5 $\square$ 6 $\square$ 7 $\square$ 8+
5) On average, I exercised how long each day:
$\square$ 0-15 mins $\square$ 15-30 mins $\square$ 30-60 mins $\square$ 60+ mins
6) When I exercised (versus when I didn't exercise) my symptoms were:
□ better □ worse
7) When I moved around (versus when I didn't move around) my symptoms were:
□ better □ worse
8) I consumed the following substances while keeping my RLS Symptom Diary:
$\square$ caffeine $\square$ alcohol $\square$ tobacco products $\square$ over-the-counter medication $\square$ prescription medication
List all medications:
9) On average, on a scale from 1-5 (with 5 being the worst) my symptoms were how severe:
$\square 1 \ \square 2 \ \square 3 \ \square 4 \ \square 5$
Questions for my healthcare provider:
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## symptoms at what time(s)? Date: consumed each item) My major stresses today were: From 1 to 5 (5 being the worst), my symptoms were how severe? I slept how many hours last night? I woke up how many times during the night, if any? after waking up for the day: Additional comments: I exercised for how many minutes today? (include the time that you substances during the day: I consumed any of these what time? I went to bed last night at I woke up today at what time? Today I experienced my RLS To be completed just before To be completed RESTLESS LEGS SYNDROME FOUNDATION PATIENT SYMPTOM DIARY O Caffeine O Alcohol O Tobacco products O Over-the-counter 0 O afternoon O midday O midmorning Times: O Other (please list) 0 O early morning evening night medications late night Day 1 O Caffeine O Alcohol O Tobacco products O Over-the-counter O Other (please list) O early morning O midmorning Times: 0 0 0 00 night midmorning evening medications late night afternoon midday O Caffeine O Alcohol O Tobacco products O Over-the-counter O Other (please list) 0 0 0 0 Times: 0 O early morning evening midmorning medications night afternoon midday late night Day 3 O Caffeine O Alcohol O Tobacco products O Over-the-counter O early morningO midmorning O Other (please list) 00 0 0 0 Times: evening night medications afternoon midday late night Day 4 O Caffeine O Alcohol O Tobacco products O Over-the-counter O Other (please list) 0 0 0 O midmorning O early morning Times: 0 evening midday medications night afternoon late night Day 5 O Caffeine O Alcohol O Tobacco products O Over-the-counter O Other (please list) Times: O night O evening O midday O midmorning O early morning O afternoon late night medications Day 6 O Caffeine O Alcohol O Tobacco products O Over-the-counter O night O evening O midday O midmorning O early morning O Other (please list) O afternoon Times: medications late night Day 7