

Augmentation Severity Rating Scale (ASRS)

INSTRUCTIONS: The examiner will ask the patient the following questions. The examiner will read the questions, explain the question, assist the patient in finding the answer, and mark the patient's answer on the form. However, it will be the patient's decision to determine which is the final answer.

Item 1 During the past week, at what time did your RLS symptoms usually start?

Please write down the time when the symptoms usually started (e.g.: 22:45).

	:		24-hr clock
HH		MM	

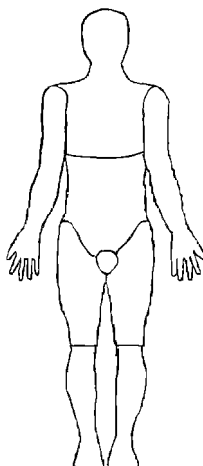
Item 2 During the past week, at any times you were sitting or resting (for example in a car, plane, theatre or watching TV) how soon afterwards did your RLS symptoms usually start?

Please indicate the time it takes for symptoms to start at various times during the day (late morning, early afternoon, late afternoon, evening before taking any RLS medication).

- 2a** When sitting in the late morning (i.e., before noon), your symptoms usually started...
- 2b** When sitting in the early afternoon (i.e., 12:00 – 15:00), your symptoms usually started...
- 2c** When sitting in the late afternoon (i.e., 15:00 – 18:00), your symptoms usually started...
- 2d** When sitting in the evening (after 18:00, before taking the first dose of RLS medication), your symptoms usually started...

2a	2b	2c	2d	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0 = After a very long time or never
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 = After a long time (i.e., after <u>about</u> an hour)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 = After a moderate amount of time (i.e., after <u>about</u> half an hour)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 = After a short time (i.e., within a few minutes)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 = Immediately or almost immediately
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-9 = Did not sit or rest over the last week

Item 3 During the past week, what parts of your body are usually affected by RLS symptoms?



Please let the patient shade in the figure the portions of his/her body affected by RLS symptoms and choose the corresponding score:

Count 1 point for any of the 8 areas:

- lower legs + feet – left/right
- upper legs – left/right
- arms + hands – left/right
- lower trunk
- upper trunk + head

Score (0 - 8)