Insomnia Severity Index (ISI)

Subject ID: ___________________________       Date: ____________

For each question below, please circle the number corresponding most accurately to your sleep patterns in the LAST 2 WEEKS.

For the first three questions, please rate the SEVERITY of your sleep difficulties.

1. Difficulty falling asleep:
   
   None    Mild    Moderate    Severe    Very Severe
   0       1        2          3          4

2. Difficulty staying asleep:
   
   None    Mild    Moderate    Severe    Very Severe
   0       1        2          3          4

3. Problem waking up too early in the morning:
   
   None    Mild    Moderate    Severe    Very Severe
   0       1        2          3          4

4. How SATISFIED/dissatisfied are you with your current sleep pattern?
   
   Very Satisfied    Satisfied    Neutral    Dissatisfied    Very Dissatisfied
   0       1        2          3          4

5. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood).
   
   Not at all    A Little    Somewhat    Much    Very Much
   Interfering Interfering Interfering Interfering Interfering
   0       1        2          3          4

6. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?
   
   Not at all    A little    Somewhat    Much    Very Much
   Noticeable Noticeable Noticeable Noticeable Noticeable
   0       1        2          3          4

7. How WORRIED/distressed are you about your current sleep problem?
   
   Not at all    A Little    Somewhat    Much    Very Much
   0       1        2          3          4