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
   - None: 0
   - Mild: 1
   - Moderate: 2
   - Severe: 3
   - Very Severe: 4

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

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

4. How SATISFIED/DISSATISFIED are you with your current sleep pattern?
   - Very Satisfied
   - Satisfied
   - Neutral
   - Dissatisfied
   - Very Dissatisfied
   - Very Satisfied: 0
   - Satisfied: 1
   - Neutral: 2
   - Dissatisfied: 3
   - Very Dissatisfied: 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
   - Not at all: 0
   - A Little: 1
   - Somewhat: 2
   - Much: 3
   - Very Much: 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
   - Not at all: 0
   - A little: 1
   - Somewhat: 2
   - Much: 3
   - Very Much: 4

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