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 MONTH.

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      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