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
   - 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