Insomnia Symptom Questionnaire

Name: date:

Instructions: If you have experienced any sleep symptoms **during the past month** please circle the appropriate number to let us know how your sleep is affecting your daily life.

During the past month did you have...	Never	Do not know	**Rarely** less than once per week	**Sometimes** 1-2 times per week	**Frequently** 3-4 times per week	**Always** 5-7 times per week	How long has the symptom lasted? (# of weeks, months or years)
1. Difficulty falling asleep?	0	1	2	3	4	5	
2. Difficulty staying asleep?	0	1	2	3	4	5	
3. Frequent awakenings from sleep?	0	1	2	3	4	5	
4. Feeling that your sleep is not sound?	0	1	2	3	4	5	
5. Feeling that your sleep is unrefreshing?	0	1	2	3	4	5	

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During the past month...	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
6. How much did your sleep problems bother you?	0	1	2	3	4
7. Have your sleep difficulties affected your work?	0	1	2	3	4
8. Have your sleep difficulties affected your social life?	0	1	2	3	4
9. Have your sleep difficulties affected other important parts of your life?	0	1	2	3	4
10. Have your sleep difficulties made you feel irritable?	0	1	2	3	4
11. Have your sleep difficulties caused you to have trouble concentrating?	0	1	2	3	4
12. Have your sleep difficulties made you feel fatigued?	0	1	2	3	4
13. How sleepy do you feel during the day?	0	1	2	3	4