**Pre-Sleep Arousal Scale**

Please describe how intensely you generally experience each of these symptoms as you attempt to fall asleep in your own bedroom.

<table>
<thead>
<tr>
<th></th>
<th>not at all</th>
<th>slightly</th>
<th>moderately</th>
<th>a lot</th>
<th>extremely</th>
</tr>
</thead>
</table>

**Somatic**

_____ 1. Heart racing, pounding, or beating irregularly.
_____ 2. A jittery, nervous feeling in your body.
_____ 3. Shortness of breath or labored breathing.
_____ 4. A tight, tense feeling in your muscles.
_____ 5. Cold feeling in your hands, feet or your body
_____ 6. Have stomach upset (knot or nervous feeling, heartburn, nausea, etc.)
_____ 7. Perspiration in the palms of your hands or other parts of your body.
_____ 8. Dry feeling in your mouth or throat.

**Cognitive**

_____ 9. Worry about falling asleep.
_____ 10. Review or ponder events of the day.
_____ 11. Depressing or anxious thoughts.
_____ 12. Worry about problems other than sleep.
_____ 13. Being mentally alert, active.
_____ 14. Can’t shut off your thoughts.
_____ 15. Thoughts keep racing through your head.
_____ 16. Being distracted by sounds, noise in the environment. (e.g., ticking of the clock, house noises, traffic).