ISI

1. Please rate the current (i.e., last 2 weeks) **SEVERITY** of your insomnia problem(s).

	None	Mild	Moderate	Severe	Very
1a. Difficulty falling asleep:	0	1	2	3	4
1b. Difficulty staying asleep:	0	1	2	3	4
1c. Problem waking up too early:	0	1	2	3	4

2. How **SATISFIED**/dissatisfied are you with your current sleep pattern?

Very Satisfied				Very Dissatisfied
0	1	2	3	4

3. 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, etc.).

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

4. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all Noticeable	Barely	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

5. How **WORRIED**/distressed are you about your current sleep problem?

Not at all	A Little	Somewhat	Much	Very Much
0	1	2	3	4