Insomnia Severity Index (ISI)

For each question below, please circle the number corresponding most accurately to your sleep patterns in the **LAST MONTH**
For the first 3 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 interfering	A Little	Somewhat	Much	Very Much 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 noticeable	A Little	Somewhat	Much	Very Much 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

Name _____
Date _____

Total Score