Pulmonary, Critical Care & Sleep Medicine Associates

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**The Insomnia Severity Index**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer the following questions by circling the most appropriate answer.**

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

 None Mild Moderate Severe Very Severe

Difficulty falling asleep: 0 1 2 3 4

Difficulty staying asleep: 0 1 2 3 4

Problem waking up too early: 0 1 2 3 4

1. How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied Satisfied Neutral Dissatisfied 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 Very much

 Interfering A little Somewhat 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 Very much

 Noticeable A little Somewhat Much noticeable

 0 1 2 3 4

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

 Not at all Very much

 Worried A little Somewhat Much worried

 0 1 2 3 4

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C.M. Morin (1993)