**Insomnia Severity Index (ISI)**

Subject ID: ________________________ Date: ______________

For each question below, please circle the number corresponding most accurately to your sleep patterns in the **LAST MONTH**.

For the first three 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   A Little Somewhat Much Very Much Interfering Interfering Interfering Interfering 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   A little Somewhat Much Very Much Noticeable Noticeable Noticeable Noticeable 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
Guidelines for Scoring/Interpretation:

Add scores for all seven items = ____
Total score ranges from 0-28

0-7  =  No clinically significant insomnia
8-14  =  Subthreshold insomnia
15-21  =  Clinical insomnia (moderate severity)
22-28  =  Clinical insomnia (severe)