ISI

1. Please rate the current (i.e., last month) SEVERITY of your insomnia problem(s):

	None	Mild	Moderate	Severe	Very
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

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

Very satisfied		Moderately 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	A little	Somewhat	Much	Very much
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

Total Score ___________