



ID: _ _ _ _ - _ _ _

Insomnia Severity Index

For each question, please **CIRCLE** the number that best describes your answer.

Please rate the **CURRENT** (i.e. **LAST 2 WEEKS**) **SEVERITY** of your insomnia problem(s).

Insomnia problem	None	Mild	Moderate	Severe	Very severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied Satisfied Moderately Satisfied Dissatisfied Very Dissatisfied
 0 1 2 3 4

5. How NOTICEABLE to others do you think your sleep 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

6. How WORRIED/DISTRESSED are you about your current sleep problem?

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

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

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

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:

0-7 = No clinically significant insomnia

8-14 = Subthreshold insomnia

15-21 = Clinical insomnia (moderate severity)

22-28 = Clinical insomnia (severe)

Print out your completed Insomnia Severity Index, along with the Guidelines for Scoring/Interpretation, to show to your health care provider.

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