

Insomnia Severity Index

Patient's Name _____

Date _____

For each question, make a single selection to check a box. Click the button to clear the form if needed.

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

Clear

	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Very</i>	
	0	1	2	3	4	Score
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0
Difficulty staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0
Problem waking up too early	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0

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

<i>Very Satisfied</i>	<i>Satisfied</i>	<i>Somewhat Satisfied</i>	<i>Dissatisfied</i>	<i>Very Dissatisfied</i>	
0	1	2	3	4	Score
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0

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.)

<i>Not at all Interfering</i>	<i>A Little Interfering</i>	<i>Somewhat Interfering</i>	<i>Much Interfering</i>	<i>Very Much Interfering</i>	
0	1	2	3	4	Score
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0

4. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

<i>Not at all Noticeable</i>	<i>A Little Noticeable</i>	<i>Somewhat Noticeable</i>	<i>Much Noticeable</i>	<i>Very Much Noticeable</i>	
0	1	2	3	4	Score
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0

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

<i>Not at all Worried</i>	<i>A Little Worried</i>	<i>Somewhat Worried</i>	<i>Much Worried</i>	<i>Very Much Worried</i>	
0	1	2	3	4	Score
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0

Guidelines for Scoring/Interpretation:

The total score is the sum of 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)

TOTAL
Score

0