Integrative Insomnia & Sleep Health Center

Name: _____ **Date:** _____

INSOMNIA SEVERITY INDEX

For each of the items below, please **circle** the number that most closely corresponds to how you feel.

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

	No Problem	Mild	Moderate Problem	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

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 does this sleep problem **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood) **CURRENTLY**?

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

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

Not at all Noticeable		Somewhat		Very Much Noticeable
0	1	2	3	4

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

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

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Beliefs and Attitudes about Sleep (DBAS)

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, circle the number that corresponds to your own personal belief. Please respond to all items even though some may not apply directly to your own situation.

1. I need 8 hours of sleep to feel refreshed and function well during the day.

Strongly Disagree — Strongly Agree
Disagree — Agree

1 2 3 4 5 6 7 8 9 10

2. When I don't get proper amount of sleep on a given night, I need to catch up the next day by napping or on the next night by sleeping longer.

Strongly Disagree — Strongly Agree

1 2 3 4 5 6 7 8 9 10

3. I am concerned that chronic insomnia may have serious consequences on my physical health.

Strongly Disagree — Strongly Agree

1 2 3 4 5 6 7 8 9 10

4. I am worried that I may lose control over my abilities to sleep.

Strongly Disagree — Strongly Agree

1 2 3 4 5 6 7 8 9 10

5. After a poor night's sleep, I know that it will interfere with my daily activities the next day.

Strongly Disagree — Strongly Agree

1 2 3 4 5 6 7 8 9 10

6. In order to be alert and function well during the day, I believe I would be better off taking a sleeping pill rather than having a poor night's sleep.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

8. When I sleep poorly on one night, I know it will disturb my sleep schedule for the whole week.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

9. Without an adequate night's sleep, I can hardly function the next day.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

10. I can't ever predict whether I'll have a good or poor night's sleep.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

11. I have little ability to manage the negative consequences of disturbed sleep.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

12. When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

13. I believe insomnia is essentially the result of a chemical imbalance.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

14. I feel insomnia is ruining my ability to enjoy life and prevents me from doing what I want.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

15. Medication is probably the only solution to sleeplessness

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

16. I avoid or cancel obligations (social, family) after a poor night's sleep.

Strongly Disagree									Strongly Agree
1	2	3	4	5	6	7	8	9	10

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SAA

Circle the one phrase for each item that best represents the extent to which you agree with that item.

When I try to fall asleep at night:

1. **my muscles are tense.**
   Strongly Disagree Disagree Agree Strongly Agree

2. **my heart is beating rapidly.**
   Strongly Disagree Disagree Agree Strongly Agree

3. **I feel "shaky" (trembling).**
   Strongly Disagree Disagree Agree Strongly Agree

4. **I become short of breath.**
   Strongly Disagree Disagree Agree Strongly Agree

5. **I become aware of my body (feeling itches, sweat, pain, nausea).**
   Strongly Disagree Disagree Agree Strongly Agree

6. **I can't stop my mind from racing.**
   Strongly Disagree Disagree Agree Strongly Agree

7. **I worry that I won't be able to fall asleep.**
   Strongly Disagree Disagree Agree Strongly Agree

8. **I worry that I won't get enough sleep.**
   Strongly Disagree Disagree Agree Strongly Agree

9. **I worry that I won't be able to function the next day if I don't sleep.**
   Strongly Disagree Disagree Agree Strongly Agree

10. **I worry that I will be tired and irritable the next day if I don't sleep.**
    Strongly Disagree Disagree Agree Strongly Agree

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MULTIDIMENSIONAL ASSESSMENT OF FATIGUE (MAF) SCALE

Instructions: These questions are about fatigue and the effect of fatigue on your activities.

For each of the following questions, circle the number that most closely indicates how you have been feeling during the past week.

For example, suppose you really like to sleep late in the mornings. You would probably circle the number closer to the "a great deal" end of the line. This is where I put it:

Example: To what degree do you usually like to sleep late in the mornings?

1 2 3 4 5 6 7 (8) 9 10

Not at all A great deal

Now please complete the following items based on the past week.

---

1. To what degree have you experienced fatigue?

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

If no fatigue, stop here.

2. How severe is the fatigue which you have been experiencing?

1 2 3 4 5 6 7 8 9 10

Mild Severe

3. To what degree has fatigue caused you distress?

1 2 3 4 5 6 7 8 9 10

No distress A great deal of distress

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In the past week, to what degree has fatigue interfered with your ability to:

(NOTE: Check box to the left of each number if you don't do activity)

☐ **4. Do household chores**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **5. Cook**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **6. Bathe or wash**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **7. Dress**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **8. Work**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **9. Visit or socialize with friends or family**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **10. Engage in sexual activity**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **11. Engage in leisure and recreational activities**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **12. Shop and do errands**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **13. Walk**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

☐ **14. Exercise, other than walking**

1 2 3 4 5 6 7 8 9 10

Not at all A great deal

15. Over the past week, how often have you been fatigued?

4 Every day

3 Most, but not all days

2 Occasionally, but not most days

1 Hardly any days

16. To what degree has your fatigue changed during the past week?

4 Increased

3 Fatigue has gone up and down

2 Stayed the same

1 Decreased

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PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half The days	Nearly Every Day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**

FOR OFFICE CODING *0* **+ _____ + _____ + _____ = Total Score: _____**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
□	□□	□□	□□

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues.

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GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half The days	Nearly Every Day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

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Life Stress Scale

Please place an "X" beside any of the following events you have experienced <u>during the past year</u>.

		X
Death of a spouse	100	_____
Divorce	73	_____
Marital Separation	65	_____
Death of close relative	63	_____
Personal injury or illness	53	_____
Marriage	50	_____
Fired from job	47	_____
Marital reconciliation	45	_____
Retirement	45	_____
Change in health of family member	44	_____
Pregnancy	40	_____
Sexual problems	39	_____
Gain of new family member	39	_____
Change in financial status	38	_____
Death of close friend	37	_____
Change to a career or line of work	36	_____
Change in number of arguments with spouse	35	_____
Mortgage or loan for major purchase	31	_____
Foreclosure of mortgage	30	_____
Change in responsibility at work	29	_____
Son or daughter leaving home	29	_____
Trouble with in-laws	29	_____
Outstanding personal achievement	28	_____
Husband/wife starting or stopping work	26	_____
Begin or end school	26	_____
Revision of personal habits	24	_____
Trouble with supervisor/ colleagues	23	_____
Change in working hours	20	_____
Change in working conditions	20	_____
Change in residence	20	_____
Change in school	20	_____
Change in recreation	19	_____
Change in church activities	19	_____
Change in social activities	18	_____
Mortgage or loan for lesser purchase (car, etc.)	17	_____
Change in sleeping habits	16	_____
Change in number of family get togethers	15	_____
Change in eating habits	15	_____
Vacation	13	_____
Christmas	12	_____
Minor violations of the law (traffic tickets, etc.)	11	_____