

## Insomnia Sleep Questionnaire Packet

(Please fill this out and bring to your insomnia consultation appointment)

### ISI

For each question, please *indicate* the number that best describes your answer.  
Please rate the **CURRENT (i.e. LAST 2 WEEKS) SEVERITY** of your insomnia problem(s).

1. Please rate the current <b>severity</b> of your insomnia.	None 0	Mild 1	Moderate 2	Severe 3	Very Severe 4
a. Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Difficulty staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Problem waking up too early	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How <b>satisfied</b> /dissatisfied are you with your current sleep pattern?	Very Satisfied 0 <input type="checkbox"/>	A Little 1 <input type="checkbox"/>	Somewhat 2 <input type="checkbox"/>	Much 3 <input type="checkbox"/>	Very Dissatisfied 4 <input type="checkbox"/>
3. To what extent do you consider your sleep problem to <b>interfere</b> with your daily functioning (e.g., daytime fatigue, ability to function at work, daily chores, concentration, memory, mood, etc.)?	Not At all Interfering 0 <input type="checkbox"/>	A Little 1 <input type="checkbox"/>	Somewhat 2 <input type="checkbox"/>	Much 3 <input type="checkbox"/>	Very Much Interfering 4 <input type="checkbox"/>
4. How <b>noticeable</b> to others do you think your sleeping problem is in terms of impairing the quality of your life?	Not At All Noticeable 0 <input type="checkbox"/>	Barely 1 <input type="checkbox"/>	Somewhat Noticeable 2 <input type="checkbox"/>	Much 3 <input type="checkbox"/>	Very Much Noticeable 4 <input type="checkbox"/>
5. How <b>worried</b> /distressed are you about your current problem?	Not At all Worried 0 <input type="checkbox"/>	A Little 1 <input type="checkbox"/>	Somewhat Worried 2 <input type="checkbox"/>	Much 3 <input type="checkbox"/>	Very Much Worried 4 <input type="checkbox"/>

### Glasgow Scale

<b><i>In the past week.....</i></b>	Very much true	To some extent true	Not at all true
1. I put too much effort into sleeping at night when it should come naturally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I feel I should be able to control my sleep at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I put off going to bed at night for fear of not being able to sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I worry about not sleeping if I am in bed at night and cannot sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I am no good at sleeping at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I get anxious about sleeping before I go to bed at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I worry about the long-term consequences of not sleeping at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY  
(SELF-REPORT) (IDS-SR)**

NAME: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

Please circle the one response to each item that best describes you for the past seven days.

1. I never take longer than 30 minutes to follow asleep.

- 0 I never take longer than 30 minutes to fall asleep
- 1 I take at least 30 minutes to fall asleep, less than half the time.
- 2 I take at least 30 minutes to fall asleep, more than half the time.
- 3 I take at least 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night:

- 0 I do not wake up at night.
- 1 I have a restless, light sleep with a few brief awakenings each night.
- 2 I wake up at least once a night, but I go back to sleep easily.
- 3 I awaken more than once a night and stay

3. Waking Up Too Early:

- 0 I never take longer than 30 minutes to fall asleep
- 1 I take at least 30 minutes to fall asleep, less than half the time.
- 2 I take at least 30 minutes to fall asleep, more than half the time.
- 3 I take at least 60 minutes to fall asleep, more than half the time.

4. Sleeping Too Much:

- 0 I sleep no longer than 7-8 hours/night, without napping during the day.
- 1 I sleep no longer than 10 hours in a 24-hour period including naps.
- 2 I sleep no longer than 12 hours in a 24-hour period including naps.
- 3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling Sad:

- 0 I do not feel sad.
- 1 I feel sad less than half the time.
- 2 I feel sad more than half the time.
- 3 I feel sad nearly all of the time.

6. Feeling Irritable:

- 0 I do not feel irritable.
- 1 I feel irritable less than half the time.
- 2 I feel irritable more than half the time.
- 3 I feel extremely irritable nearly all of the time.

7. Feeling Anxious or Tense:

- 0 I do not feel anxious or tense.
- 1 I feel anxious (tense) less than half the time.
- 2 I feel anxious (tense) more than half the time.
- 3 I feel extremely anxious (tense) nearly all of the time.

8. Response of Your Mood to Good or Desired Events:

- 0 My mood brightens to a normal level which lasts for several hours when good events occur.
- 1 My mood brightens but I do not feel like my normal self when good events occur.
- 2 My mood brightens only somewhat to a rather limited range of desired events.
- 3 My mood does not brighten at all, even when very good or desired events occur in my life.

9. Mood in Relation to the Time of Day:

- 0 There is no regular relationship between my mood and the time of day.
- 1 My mood often relates to the time of day because of environmental events (e.g., being alone, working).
- 2 In general, my mood is more related to the time of day than to environmental events.
- 3 My mood is clearly and predictably better or worse at a particular time each day.

9A. Is your mood typically worse in the morning, afternoon or night? (circle one)

9A Is your mood variation attributed to the environment? (yes or no) (circle one)

10. The Quality of Your Mood:

- 0 The mood (internal feelings) that I experience is very much a normal mood.
- 1 My mood is sad, but this sadness is pretty much like the sad mood I would feel if someone close to me died or left.
- 2 My mood is sad, but this sadness has a rather different quality to it than the sadness I would feel if someone close to me died or left.
- 3 My mood is sad, but this sadness is different from the type of sadness associated with grief or loss.

**Please complete either 11 or 12 (not both)**

11. Decreased Appetite:

- 0 There is no change in my usual appetite.
- 1 I eat somewhat less often or lesser amounts of food than usual.
- 2 I eat much less than usual and only with personal effort.
- 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

12. Increased Appetite:

- 0 There is no change from my usual appetite.
- 1 I feel a need to eat more frequently than usual.
- 2 I regularly eat more often and/or greater amounts of food than usual.
- 3 I feel driven to overeat both at mealtime and between meals.

**Please complete either 13 or 14 (not both)**

13. Decreased Weight (Within the Last Two Weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight loss.
- 2 I have lost 2 pounds or more.
- 3 I have lost 5 pounds or more.

14. Increased Weight (Within the Last Two Weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight gain.
- 2 I have gained 2 pounds or more.
- 3 I have gained 5 pounds or more.

15. Concentration/Decision Making:

- 0 There is no change in my usual capacity to concentrate or make decisions.
- 1 I occasionally feel indecisive or find that my attention wanders.
- 2 Most of the time, I struggle to focus my attention or to make decisions.
- 3 I cannot concentrate well enough to read or cannot make even minor decisions.

16. View of Myself:

- 0 I see myself as equally worthwhile and deserving as other people.
- 1 I am more self-blaming than usual.
- 2 I largely believe that I cause problems for others.
- 3 I think almost constantly about major and minor defects in myself.

17. View of My Future:

- 0 I have an optimistic view of my future.
- 1 I am occasionally pessimistic about my future, but for the most part I believe things will get better.
- 2 I'm pretty certain that my immediate future (1-2 months) does not hold much promise of good things for me.
- 3 I see no hope of anything good happening to me anytime in the future.

18. Thoughts of Death or Suicide:

- 0 I do not think of suicide or death.
- 1 I feel that life is empty or wonder if it's worth living.
- 2 I think of suicide or death several times a week for several minutes.
- 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

19. General Interest:

- 0 There is no change from usual in how interested I am in other people or activities.
- 1 I notice that I am less interested in people or activities.
- 2 I find I have interest in only one or two of my formerly pursued activities.
- 3 I have virtually no interest in formerly pursued activities.

20. Energy Level:

- 0 There is no change in my usual level of energy.
- 1 I get tired more easily than usual.
- 2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
- 3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

21. Capacity for Pleasure or Enjoyment (excluding sex):

- 0 I enjoy pleasurable activities just as much as usual.
- 1 I do not feel my usual sense of enjoyment from pleasurable activities.
- 2 I rarely get a feeling of pleasure from any activity.
- 3 I am unable to get any pleasure or enjoyment from anything.

22. Interest in Sex (Please Rate Interest, not Activity):

- 0 I'm just as interested in sex as usual.
- 1 My interest in sex is somewhat less than usual or I do not get the same pleasure from sex as I used to.
- 2 I have little desire for or rarely derive pleasure from sex.
- 3 I have absolutely no interest in or derive no pleasure from sex.

23. Feeling slowed down:

- 0 I think, speak, and move at my usual rate of speed.
- 1 I find that my thinking is slowed down or my voice sounds dull or flat.
- 2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
- 3 I am often unable to respond to questions without extreme effort.

24. Feeling restless:

- 0 I do not feel restless.
- 1 I'm often fidgety, wring my hands, or need to shift how I am sitting.
- 2 I have impulses to move about and am quite restless.
- 3 At times, I am unable to stay seated and need to pace around.

25. Aches and pains:

- 0 I don't have any feeling of heaviness in my arms or legs and don't have any aches or pains.
- 1 Sometimes I get headaches or pains in my stomach, back or joints but these pains are only sometime present and they don't stop me from doing what I need to do.
- 2 I have these sorts of pains most of the time.
- 3 These pains are so bad they force me to stop what I am doing.

26. Other bodily symptoms:

- 0 I don't have any of these symptoms: heart pounding fast, blurred vision, sweating, hot and cold flashes, chest pain, heart turning over in my chest, ringing in my ears, or shaking.
- 1 I have some of these symptoms but they are mild and are present only sometimes.
- 2 I have several of these symptoms and they bother me quite a bit.
- 3 I have several of these symptoms and when they occur I have to stop doing whatever I am doing.

27. Panic/Phobic symptoms:

- 0 I have no spells of panic or specific fears (phobia) (such as animals or heights).
- 1 I have mild panic episodes or fears that do not usually change my behavior or stop me from functioning.
- 2 I have significant panic episodes or fears that force me to change my behavior but do not stop me from functioning.
- 3 I have panic episodes at least once a week or severe fears that stop me from carrying on my daily activities.

28. Constipation/diarrhea:

- 0 There is no change in my usual bowel habits.
- 1 I have intermittent constipation or diarrhea which is mild.
- 2 I have diarrhea or constipation most of the time but it does not interfere with my day-to-day functioning.
- 3 I have constipation or diarrhea for which I take medicine or which interferes with my day-to-day activities.

29. Interpersonal Sensitivity:

- 0 I have not felt easily rejected, slighted, criticized or hurt by others at all.
- 1 I have occasionally felt rejected, slighted, criticized or hurt by others.
- 2 I have often felt rejected, slighted, criticized or hurt by others, but these feelings have had only slight effects on my relationships or work.
- 3 I have often felt rejected, slighted, criticized or hurt by others and these feelings have impaired my relationships and work.

30. Leadon Paralysis/Physical Energy:

- 0 I have not experienced the physical sensation of feeling weighted down and without physical energy.
- 1 I have occasionally experienced periods of feeling physically weighted down and without physical energy, but without a negative effect on work, school, or activity level.
- 2 I feel physically weighted down (without physical energy) more than half the time.
- 3 I feel physically weighted down (without physical energy) most of the time, several hours per day, several days per week.