DRS. GIRGIS & ASSOCIATES
Breathe Better, Hear Better, Sleep Better
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Hinsdale Sleep Center

Insomnia Severity Index

Patient Name: _____ Today's Date: _____ Pt Acct# _____

Instructions: *Please circle the appropriate response for each item.*

******"CURRENT" is meant to refer to the last 2 weeks****. If the last 2 weeks were unusual for any reason (e.g., illness, vacation), please consider the most recent 2-week period which you think most represents your current symptoms.*

Please rate the CURRENT severity of each sleep problem listed below.	**None/Not Applicable**	**Mild**	**Moderate**	**Severe**	**Very Severe**
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Waking up earlier than intended	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. 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 all day/daily chores, concentration, memory, mood, etc.) CURRENTLY?

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

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

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

7. 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 on the Insomnia Severity Index: _____