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.

Clear

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

	None 0	*Mild* 1	*Moderate* 2	*Severe* 3	*Very* 4	Score
Difficulty falling asleep	☐	☐	☐	☐	☐	0
Difficulty staying asleep	☐	☐	☐	☐	☐	0
Problem waking up too early	☐	☐	☐	☐	☐	0

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

Very Satisfied 0	*Satisfied* 1	*Somewhat Satisfied* 2	*Dissatisfied* 3	*Very Dissatisfied* 4	
☐	☐	☐	☐	☐	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.)

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

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 0	*A Little Noticeable* 1	*Somewhat Noticeable* 2	*Much Noticeable* 3	*Very Much Noticeable* 4	
☐	☐	☐	☐	☐	0

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

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