Insomnia Severity Index (ISI)

Name: _____ **Date:** _____

1. Please rate the current (i.e., last week) **SEVERITY** of your insomnia problem(s).

	<30 min None	**30-45** Mild	**45-90** Moderate	**90-120** Severe	**>120** Very
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				Very Dissatisfied
0	1	2	3	4

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	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

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

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

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

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

Score	Significance
0-7	People without insomnia tend to score in this range.
8-14	People with relatively mild insomnia symptoms score in this range.
15-21	People with moderately severe insomnia tend to score in this range.
22-28	People with severe insomnia symptoms score in this range.

Most people who are diagnosed with insomnia score above 15.