Ages 4 to 11 yo

SLEEP EVALUATION QUESTIONNAIRE

Name: _____

Date of Birth: _____ **Age:** _____ **Gender:** _____ height _____ cm

School: _____ weight _____ kg

Grade: _____ **Enrolment in any special educational class:** _____

Health Card Number: _____ **Version code:** _____

Email patient _____ **Phone:** _____

Parent/caregiver's name: _____

Relationship to patient: _____

Address: _____

_____

_____

Telephone: _____

Email parent: _____

Who referred you for a sleep evaluation? _____

Telephone: _____ **Fax:** _____ **Cellular no.:** _____

Email: _____

Family Doctor/Pediatrician: _____

Address: _____

_____ Postal Code: _____

_____

Telephone: _____ **Fax:** _____

Other physicians, psychologists, care givers, etc. who should be notified about the sleep assessment:

1. Name: _____
   Address: _____
   _____ Postal Code _____
   _____
   Role: _____

2. Name: _____
   Address: _____
   _____ Postal Code: _____
   _____
   Role: _____

Please describe the current sleep difficulty: (a check-list of common sleep symptoms may be useful)

_____

_____

_____

_____

_____

What questions do you hope will be answered by coming to the sleep clinic?

Mother's Concerns: _____

_____

Mother's Occupation: _____

Father's Concerns: _____

_____

Father's Occupation: _____

Patients' Concerns: _____

_____

What aspects of child's life are affected by the sleep problems (e.g. growth, pain, grades, mood)?

_____

_____

_____

_____

Please note that occasionally questions are repeated as part of the different scales. While we realize that this may be frustrating to you and appear unorganized on our part, the replication is absolutely necessary, as part of the different rating scales we use. Without that replication the measures would not be valid. Please bear with us. This questionnaire was carefully constructed over several years.

SLEEP HABITS

"You" is for teenagers completing this questionnaire.

1. What time do you/your child usually go to bed on **school nights**? _____

2. What is the main reason you go /your child goes to bed at a particular time? (check ONE below)
_____a. Because it fits best with the family's schedule
_____b. Because she/he feels sleepy then
_____c. Because that is when his/her TV shows are over
_____d. Because that is when his/her siblings go to bed
_____e. Other (describe briefly) _____

3. What time do you/your child usually wake up on **school day** morning's? _____

4. What usually wakes you/your child in the morning on **school days**? (check ONE below)
_____a. alarm clock
_____b. parent or other family member
_____c. noise
_____d. need to go to the bathroom
_____e. spontaneous
_____f. other (describe briefly)

5. Which of the following applies to waking you/your child in the morning on **school days**? (check ONE only)
_____a. almost always have great difficulty getting him/her out of bed
_____b. sometimes have great difficulty getting him/her out of bed
_____c. seldom have great difficulty getting him/her out of bed
_____d. never have great difficulty getting him/her out of bed

6. What time do you/your child usually go to bed on **weekend** nights? _____

7. What time do you you/your child usually wake up on **weekend** mornings? _____

8. What usually wakes up you/your child in the morning on weekends (check ONE below)
_____a. alarm clock
_____b. parent or other family member
_____c. noise
_____d. need to go to the bathroom
_____e. spontaneous
_____f. other (describe briefly) _____

9. Which of the following applies to waking you/your child in the morning on **weekends**? (check ONE below):
_____a. almost always have great difficulty getting out of bed
_____b. sometimes have great difficulty getting out of bed
_____c. seldom have great difficulty getting out of bed
_____d. never have great difficulty getting out of bed

10. How long does it typically take you/your child to fall asleep in minutes? _____

11. How many times per night do you/your child awaken? _____

12. Approximately how many hours of sleep do you/your child get most nights? _____

13. Do you/your child wake up feeling unrefreshed in the morning? Yes/ No

14. Do you/your child complain of feeling sleepy during the day? Yes/ No

15. Do your/your child's teacher/other supervisor comment that you/your child fell asleep during the day? Yes/ No

16. Do you/your child take daytime naps? (circle one) Yes/ No

17. If so, how long are your/your child's naps? _____

18. If there are naps, are daytime naps refreshing? Yes/ No

19. Do you/your child report dreaming during these naps? Yes/ No

20. At what age did you/your child give up naps? _____

21. How many motor vehicle collisions have you (or your child) been involved in? _____

22. Did you/your child suffer from any head injury in those car accidents? _____

23. If applicable, were you a driver? _____

24. How many work/sport related injuries have occurred to you/your child? _____

25. Have you/your child ever injured yourself because of falling asleep? _____

---

26. Does your child sleep in the same bed with you? Yes / No

27. Is he/she very active in bed? Yes / No

---

28. Behaviors during sleep: does your child/do you?

	Never	Rarely	Sometimes	Often
Wake up more than twice/night				
After waking has trouble falling asleep again				
Twitches or jerks legs				
Has excessive night sweats				
Sleep walks				
Sleep talks				
Grinds teeth				
Wakes up crying or upset				
Nightmares				
Rocks body				
Bangs head				
Vomits				
Coughs				
Wets the bed				

Answer these questions ONLY if you/your child is **bed-wetting** and over 5 years of age (otherwise go to Question 39)

29. Do you/your child have frequent urination? Yes/ No

30. Do you/your child have pain in urination? Yes/ No

31. Do you/your child have a history of bladder infection? Yes/ No

32. Do you/your child have any allergies? Yes/ No

33. Do you/your child have seizures? Yes/ No

34. If there is currently bed wetting, was there a time when it did not occur? Yes/ No

35. Do you/your child have a problem of being wet during the day? Yes/ No

36. Do you/your child have bed wetting during the night? Yes/ No

37. Do you/your child have back problems (for example, spina bifida)? Yes/ No

38. Do you/your child have a family history of bed wetting? Yes/ No

HEALTH HABITS- Please answer the following questions regarding health habits which may impact sleep. **In the past four weeks, on average:**

	None	Less than 1 a day	1-3 a day	More than 3 a day
39a. How much caffeinated soda did you/your child drink?				
39b. How much did you/your child use tobacco products?				
39c. How much coffee/tea did you/your child drink?				

40. How much television and/or videos did you/your child watch on school days?
☐ 0-1 hours per day ☐ between 2 and 4 hours ☐ don't know
☐ 1-2 hours per day ☐ more than 4 hours

41. How much time do you/your child spend on the computer on school days?
☐ 0-1 hours per day ☐ between 2 and 4 hours ☐ don't know
☐ 1-2 hours per day ☐ more than 4 hours

42. How much television and/ or videos did you/your child watch on weekend days?
☐ 0-1 hours per day ☐ between 2 and 4 hours ☐ don't know
☐ 1-2 hours per day ☐ more than 4 hours

43. How much time do you/your child spend on the computer on weekend days?
☐ 0-1 hours per day ☐ between 2 and 4 hours ☐ don't know
☐ 1-2 hours per day ☐ more than 4 hours

44. How many times per week did you/your child watch TV and/or videos within the 30 minutes before falling asleep?
☐ 1-2 nights ☐ 3-4 nights ☐ 5-6 nights
☐ Every night ☐ Not at all

45. How many times per week did your child use a cell phone in the 30 minutes before falling asleep?

☐ 1-2 nights ☐ 3-4 nights ☐ 5-6 nights
☐ Every night ☐ Not at all

46. How many times per week did your child use Facebook (or some other social networking website) in the 30 minutes before falling asleep?

☐ 1-2 nights ☐ 3-4 nights ☐ 5-6 nights
☐ Every night ☐ Not at all

47. Do you/your child have a television set in your bedroom? ☐ **Yes** ☐ **No**

Current School Performance

In what grade is your child?_____

Has your child ever repeated a grade? ☐ Yes ☐ No

Is your child enrolled in any special education class? ☐ Yes ☐ No

How many school days has your child missed so far this year? (in the school month) _____

How many school days was your child late so far this year? (in the school month) _____

Child's grades this year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Does your child take part in any activities outside school?

_____
_____
_____
_____
_____

PATIENT MEDICAL HISTORY

Developmental Milestones

1. The mother's pregnancy with the child was: ☐ Normal ☐ Complicated

2. The mother's delivery of the child was: ☐ Term ☐ Post-term ☐ Pre-term

3. Birth weight _____

4. Was the child breast fed? Yes/No If yes, till what age? _____

5. At what age did the child crawl? _____

6. At what age did the child sit up? _____

7. At what age did the child walk? _____

8. At what age did the child speak single words? (other than mama or dada) _____

9. At what age did the child say two or more words? _____

10. At what age was the child toilet trained (bladder)? _____

11. At what age was the child toilet trained (bowel control)? _____

12. Have you/your child had any of the following conditions:

___Asthma
___Sinus problems
___Chronic bronchitis
___Frequent colds
___Frequent ear infections
___Head trauma
___Acid reflux
___Heart disease
___Loss of consciousness
___Seizures
___Thyroid or endocrine problems
___High blood pressure
___Diabetes
___Eczema
___Genetic disorder
___Chromosome problem
___Cranio-facial disorder
___Any other medical disorder (please list)

_____

13. Any major surgery?

_____

_____

_____

_____

If yes, at what age_____ ☐ No complications _____ ☐ Complications_____

14. a. Has your child ever had his/her tonsils removed: ☐ Yes ☐ No
If yes, at what age?_____

b. Has your child ever had his/her adenoid removed: ☐ Yes ☐ No
If yes, at what age_____

c. Has your child had craniofacial procedures: ☐ Yes ☐ No
If yes, at what age_____

15. Any history of hospitalizations?

_____

_____

If yes, at what age_____

16. Please list all currently prescribed medications and the doses:

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

17. Any known allergies: ☐ Yes ☐ No

If yes, please provide details:
Foods_____ Pets/animals_____
Medications_____ Latex_____
Exercise_____ Seasonal/weather_____
Other:_____

18. Immunizations: Up to date Yes / No Any reactions to vaccines ? Yes/No

If yes, which vaccine? _____

H1N1 Vaccination received? Yes/No Date: _____ Any Reaction? Yes/No

If yes, please describe: _____

19. Please list your child's past psychiatric history and age of diagnosis:
If you know the name of the doctor or professional who made the diagnosis please note it here:

_____

_____

_____

Diagnosis	Check if relevant	Age of diagnosis
Depression		
Anxiety/Panic attack		
Obsessive Compulsive Disorder		
ADHD/ADD		
Autism		
Developmental delay		
Tourette's syndrome		
Pervasive developmental disorder		
Asperger syndrome		
Learning disability		
Behavioral disorder		
Fetal Alcohol syndrome		
Substance abuse		
Other psychiatric diagnosis		

Please provide further details: _____

_____

_____

20. SUBSTANCE ABUSE: ☐ No known history of any alcohol or drug use

Please indicate any substance used currently or in the past by you (or your child)

	Current	Past
Alcohol	☐	☐
Marijuana	☐	☐
Ecstasy	☐	☐
Huffing (gas, aerosol etc)	☐	☐
Other :	☐	☐

FAMILY INFORMATION

21. What best describes your/the child's living situation? (please circle)

Family home Adopted home Foster home Group home

22. Do you/your child spend time in more than one household? (eg. If parents divorced?)

☐ No ☐ Yes **(if yes, please specify: _____)**

_____

23. Please list all members of the households in which you/your child lives full or part-time:

Members of the household	Relationship	Age

24. Mother's marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

If divorced, child's custody with:

_____

Mother's Education: _____

25. Father's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

If divorced, child's custody with: _____

Father's Education: _____

26. Family Sleep History: Please tick all boxes that apply:

	Brother	Brother 2	Sister	Sister 2	Father	Mother	Other (specify)
Sleep Walking							
Screaming During Sleep							
Very Loud Snoring in Sleep							
Sleep Apnea							
Daytime Sleepiness							
Insomnia							
Chronic Fatigue							
Epilepsy							
Mental Illness							
Death During Sleep							
Bedwetting							
Depression							
Anxiety							
Restless Legs							
Parkinson's Disease							
Heart Disease							
Diabetes							
Thyroid problems							

27. What best describes your/your child's ethnic background?

Place of birth: _____

Other languages known: _____

Primary country of schooling: _____

How long have you/your child been in Canada?_____

How you would define yourself/your child?

☐ White / ☐ Asian / ☐ Black / ☐ Hispanic / ☐ other_____

Thank you for completing this questionnaire!

Pediatric Sleep Questionnaire

Patient Name: _____

Date of Birth: _____

While sleeping does your child...	Yes	NO	Don't Know
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have "heavy" or loud breathing?			
Have trouble breathing or struggle to breathe?			
Have you ever...			
Seen your child stop breathing during the night?			
Does your child....			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Wake up feeling un-refreshed in the morning?			
Have a problem with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
This child often...			
Does not seem to listen when spoken to directly			
Has difficulty organizing tasks			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Is "on the go" or often acts as if "driven by a motor"			
Interrupts or intrudes on others (e.g. butts into conversations or games)			

Total Number of "Yes" Responses _____

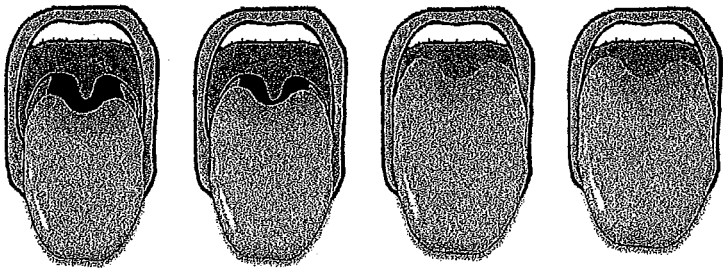
If eight or more statements are answered "yes", consider referring for sleep evaluation

CHERVINE ET AL, PEDIATRIC SLEEP QUESTIONNAIRE: VALIDITY AND RELIABILITY OF SCALES FOR SLEEP DISORDERED BREATHING, SNORING, SLEEPINESS, AND BEHAVIORAL PROBLEMS, SLEEP MEDICINE 2000;1:21-32

A short pediatric sleep apnea questionnaire

I	**I**s your child often Irritated or angry during the day?	Yes ❑	No ❑
M	Body **M**ass index above the 85th percentile?	Yes ❑	No ❑
S	Does your child usually **S**nore?	Yes ❑	No ❑
L	Does your child sometimes have **L**abored breathing at night?	Yes ❑	No ❑
E	**E**ver noticed a stop in your child's breathing at night?	Yes ❑	No ❑
E	Does your child have **E**nlarged tonsils and/or adenoids?	Yes ❑	No ❑
P	Does your child have **P**roblems with concentration?	Yes ❑	No ❑
Y	Does your child often **Y**awn or is often tired/sleepy during the day?	Yes ❑	No ❑

3 or more positive responses suggests Sleep Apnea.



Class I Class II Class III Class IV

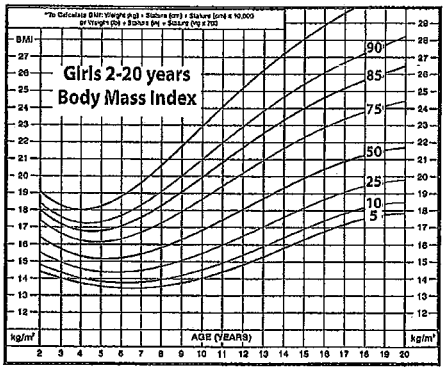
The Mallampati Score

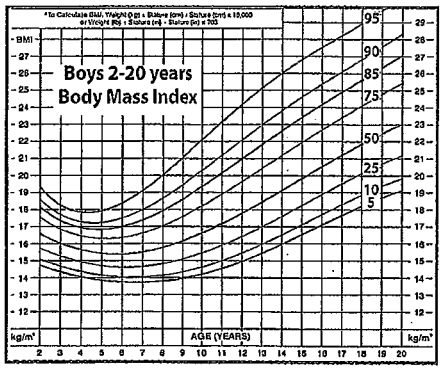
Class I: Complete visualization of the soft palate

Class II: Complete visualization of the uvula

Class III: Visualization of only the base of the uvula

Class IV: Soft palate is not visible at all





Kadmon G, Chung SA, Shapiro CM. I'M SLEEPY: a short pediatric sleep apnea questionnaire. Int J Pediatr Otorhinolaryngol. 2014;;78(12):2116-20.

PEDIATRIC DAYTIME SLEEPINESS SCALE (PDSS)

(completed by adolescent over 11 years or by a parent for children aged 5-10)

Please answer the following questions as honestly as you can by putting a tick mark in the appropriate box.

	Always	Frequently	Sometimes	Seldom	Never
1. How often do you fall asleep or get drowsy during class periods?					
2. How often do you get sleepy or drowsy while doing your homework?					
3. Are you usually alert most of the day?					
4. How often are you ever tired and grumpy during the day?					
5. How often do you have trouble getting out of bed in the morning?					
6. How often do you fall back to sleep after being awakened in the morning?					
7. How often do you need someone to awaken you in the morning?					
8. How often do you think that you need more sleep?					

Restless Legs Syndrome (Parent Version)

1. Does your child have "growing pains" ? (Check one)

_____never _____ occasionally _____ sometimes _____ frequently

less than 1x/month 1-2x/month 1-2x/wk to daily

2. Does your child complain of uncomfortable or funny feeling (creeping, crawling, tingling) in his/her legs? (Check one)

_____never _____ occasionally _____ sometimes _____ frequently

less than 1x/month 1-2x/month 1-2x/wk to daily

3. Does your child	**YES**	**NO**	**DON'T KNOW**
A. Notice funning feeling in his/her legs (or do they seem worse) when lying down or sitting?	--------	--------	--------
B. Have partial relief with movement (wiggling feet, toes, or walking)	--------	--------	--------
C. Complain that the feeling are worse at night?	--------	--------	--------
D. Have a lot of fidgeting or wiggling of the feet or toes when sitting or lying down?	--------	--------	--------
E. Have repeated jerking movements in toes or legs or the whole body while sleeping?	--------	--------	--------

4. Does your child appear restless while sleeping (thrashing around, banging feet against wall, twisting covers, or falling out of bed)? (Check one)

_____never _____ occasionally _____ sometimes _____ frequently

less than 1x/month 1-2x/month 1-2x/wk to daily

5. Does your child seem more restless, fidgety or hyperactive than most children his/her age?

_____never _____ occasionally _____ sometimes _____ frequently

less than 1x/month 1-2x/month 1-2x/wk to daily

6a. Has anyone in the family (including grandparents, aunts/uncles) been diagnosed with restless legs or periodic leg movements during sleep? _____YES _____ NO if so, who:_____

6b. Does anyone in the family have severe problems falling or staying asleep?
If so, who: _____ type of problem, if known: _____

7. How often, on average, does your child consume caffeine-containing beverages or food? (coffee, tea, cola beverages, chocolate)

_____never _____ occasionally _____ sometimes _____ frequently

less than 1x/month 1-2x/month 1-2x/wk to daily

8. Has your child ever been diagnosed and/or treated for anemia?
Yes_____ No_____ Don't Know _____
Date, type of anemia, and treatment, if known: _____

1. Have you/your child ever become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something? Yes/ No

2. Have you/your child ever felt unable to move for a short period, in bed, though awake and able to look around? Yes/ No

3. Have you/your child felt an irresistible urge to take a nap at times, forcing you to stop what you are doing in order to sleep? Yes/ No

4. Have you/your child ever had a sense of carrying on dreaming after waking up? Yes/ No

Periodic Leg Movement Syndrome

Does the child...		YES	NO	Don't Know
1.	describe restlessness of the legs when in bed?			
2.	have "growing pains" (unexplained leg pains) that are worse in bed?			
3.	usually get out of bed at night?			
4.	wake up more than twice a night on average?			
5.	wake up feeling unrefreshed in the mornings? ?			
6.	wake up with headaches in the mornings?			

SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "not" true or "hardly ever true" / "somewhat true or sometimes true" "very true or often true" for you/your child. Then for each sentence, tick the box that corresponds to the response that seems to describe you or your child for the **last 3 months**. If a parent completes, please bear in mind that the phrases are written as if the child/adolescent completes it.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	3 Very True or Often True
1. When I feel frightened, it is hard to breathe	☐	☐	☐
2. I get headaches when I am at school	☐	☐	☐
3. I don't like to be with people I don't know well	☐	☐	☐
4. I get scared if I sleep away from home	☐	☐	☐
5. I worry about other people liking me	☐	☐	☐
6. When I get frightened, I feel like passing out	☐	☐	☐
7. I am nervous	☐	☐	☐
8. I follow my mother or father wherever they go	☐	☐	☐
9. People tell me that I look nervous	☐	☐	☐
10. I feel nervous with people I don't know well	☐	☐	☐
11. I get stomach aches at school	☐	☐	☐
12. When I get frightened, I feel like I am going crazy	☐	☐	☐
13. I worry about sleeping alone	☐	☐	☐
14. I worry about being as good as other kids	☐	☐	☐
15. When I get frightened I feel like things are not real	☐	☐	☐
16. I have nightmares about something bad happening to my parents	☐	☐	☐
17. I worry about going to school	☐	☐	☐
18. When I get frightened my heart beats fast	☐	☐	☐
19. I get shaky	☐	☐	☐
20. I have nightmares about something bad happening to me	☐	☐	☐

- Continued on next page -

SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	3 Very True or Often True
21. I worry about things working out for me	☐	☐	☐
22. When I get frightened, I sweat a lot	☐	☐	☐
23. I am a worrier	☐	☐	☐
24. I get really frightened for no reason at all	☐	☐	☐
25. I am afraid to be alone in the house	☐	☐	☐
26. It is hard for me to talk with people I don't know well	☐	☐	☐
27. When I get frightened, I feel like I am choking	☐	☐	☐
28. People tell me that I worry too much	☐	☐	☐
29. I don't like to be away from my family	☐	☐	☐
30. I am afraid of having anxiety (or panic) attacks	☐	☐	☐
31. I worry something bad might happen to my parents	☐	☐	☐
32. I feel shy with people I don't know well	☐	☐	☐
33. I worry about what is going to happen in the future	☐	☐	☐
34. When I get frightened, I feel like throwing up	☐	☐	☐
35. I worry about how well I do things	☐	☐	☐
36. I am scared to go to school	☐	☐	☐
37. I worry about things that have already happened	☐	☐	☐
38. When I get frightened, I feel dizzy	☐	☐	☐
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	☐	☐	☐
40. I feel nervous when I am going to parties, dances, or any place where there will be people I don't know well.	☐	☐	☐
41. I am shy	☐	☐	☐

CENTER FOR EPIDEMIOLOGICAL STUDIES DEPRESSION SCALE FOR CHILDREN (CES-DC)

(For children over 8 years)

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the **past week.**

	0 Not at all	1 A little	2 Some	3 A lot
1. I was bothered by things that usually don't bother me				
2. I did not feel like eating, I wasn't very hungry				
3. I wasn't able to feel happy, even when my family or friends tried to make me feel better				
4. I felt like I was just as good as other kids				
5. I felt like I couldn't pay attention to what I was doing.				
6. I felt down and unhappy				
7. I felt like I was too tired to do things				
8. I felt like something good was going to happen				
9. I felt things I did before didn't work out right				
10. I felt scared				
11. I didn't sleep as well as I usually sleep				
12. I was happy				
13. I was more quiet than usual				
14. I felt lonely, like I didn't have any friends				
15. I felt like kids I know were not friendly or that they didn't want to be with me				
16. I had a good time				
17. I felt like crying				
18. I felt sad				
19. I felt people didn't like me				
20. It was hard to get started doing things				

For office use only:

Score:

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	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. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

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

6. How WORRIED/DISTRESSED are you about your current sleep problem?

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

7. 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/daily chores, concentration, memory, mood, etc.) CURRENTLY?

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

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)