

## Insomnia Severity Index

Please rate the *CURRENT (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 OR 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 OR 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, etc.)?

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

Total Score: \_\_\_\_\_

For score interpretation, clinical decision support tools, and patient education materials, please go to:

<https://voices.uchicago.edu/behavioralhealthintegrationprogram/>