Insomnia screening questionnaire – For use if difficulty sleeping for 4 weeks or more

Over the past month:		Circle the best answer				
		Never	Rarely	Occasionally	Most nights/days	Always
1	Do you have trouble falling asleep?	1	2	3	4	5
2	Do you have trouble staying asleep?	1	2	3	4	5
3	Do you wake up un-refreshed?	1	2	3	4	5
4	Do you take anything to help you sleep?	1	2	3	4	5
5	Do you use alcohol to help you sleep?	1	2	3	4	5
6	Do you have any medical condition that disrupts your sleep?	1	2	3	4	5
7	Have you lost interest in hobbies or activities?	1	2	3	4	5
8	Do you feel sad, irritable, or hopeless?	1	2	3	4	5
9	Do you feel nervous or worried?	1	2	3	4	5
10	Do you think something is wrong with your body?	1	2	3	4	5
11	Are you a shift worker or is your sleep schedule irregular?	1	2	3	4	5
12	Are your legs restless and/or uncomfortable before bed?	1	2	3	4	5
13	Have you been told that you are restless or that you kick your legs in your sleep?	1	2	3	4	5
14	Do you have any unusual behaviours or movements during sleep?	1	2	3	4	5
15	Do you snore?	1	2	3	4	5
16	Has anyone said that you stop breathing, gasp, snort, or choke in your sleep?	1	2	3	4	5
17	Do you have difficulty staying awake during the day?	1	2	3	4	5