

How often do you:

	Never	Sometimes	Often
Depend on an alarm to wake up?	1	2	3
Sleep more than one hour past usual wake up time?	1	2	3
Have a very difficult time waking up?	1	2	3
Feel unable to move when waking up?	1	2	3
Have dream-like images when waking up even though you know you're not asleep?	1	2	3
Wake up confused or disoriented?	1	2	3
Wake up with a headache?	1	2	3
Wake up nauseous?	1	2	3
Wake up with a dry mouth?	1	2	3
Wake up 1 or 2 hours before you have to get up?	1	2	3
Feel afraid that you won't return to sleep after waking?	1	2	3
Sleep with someone else in your room?	1	2	3
Sleep with someone else in your bed?	1	2	3
Have restless, disturbed sleep?	1	2	3
Get up at night to attend to your children or something else?	1	2	3
Snore loudly?	1	2	3
Feel your heart pounding during the night?	1	2	3
Sweat a lot during the night?	1	2	3
Walk in your sleep?	1	2	3
Fall out of bed while asleep?	1	2	3
Wake up screaming, violent or confused?	1	2	3
Have unusual movements while asleep?	1	2	3
Wet the bed?	1	2	3
Have dreams?	1	2	3
Feel sleepy during the day?	1	2	3
Fall asleep unintentionally?	1	2	3
Have thoughts racing through your mind?	1	2	3
Feel sad or depressed?	1	2	3
Have anxiety?	1	2	3
Feel muscular tension?	1	2	3
Feel weakness in your muscles when laughing, surprised, angry, excited?	1	2	3

My sleep is frequently disturbed by (check all that are true):

- Heat
- Cold
- Light
- Noise
- Noise/movement of bed partner
- Asthma
- Cough
- Shortness of breath
- Choking
- Indigestion, gas, heartburn
- Hunger
- Thirst
- Need to urinate
- Chest pain
- Creeping, crawling or aching feeling in your legs (like you have to move them)
- Frightening dreams

Sleep Impairment Index

Please rate the current severity of your insomnia problem(s):

	None			Very Severe	
Difficulty falling asleep	1	2	3	4	5
Difficulty staying asleep	1	2	3	4	5
Problem waking up too early	1	2	3	4	5

How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied	Moderately satisfied			Very dissatisfied
1	2	3	4	5

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	A little	Somewhat	Much	Very Much
1	2	3	4	5

Now NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all	A little	Somewhat	Much	Very Much
1	2	3	4	5

How CONCERNED are you about your current sleep problem?

Not at all	A little	Somewhat	Much	Very Much
1	2	3	4	5

To what extent do you believe the following factors are contributing to your sleep problem?

	None		Some		Much
Cognitive/Thought disturbances (racing thoughts)	1	2	3	4	5
Somatic/Physical disturbances (muscle pain/tension)	1	2	3	4	5
Bad sleeping habits:	1	2	3	4	5
Natural aging process:	1	2	3	4	5

After a poor night's sleep, which of the following problems do you experience on the next day?
(Check all that apply):

- Daytime fatigue: tired, exhausted, washed out, sleepy
- Difficulty functioning: performance impairment at work/daily chores, difficulty concentrating, memory problems
- Mood problems: irritable, tense, nervous, groggy, depressed, anxious, grouchy, hostile, angry, confused
- Physical symptoms: muscle aches/pain, light-headed, headache, nausea, heartburn, muscle tension
- None

Beliefs and Attitudes about Sleep Scale

Please indicate the extent to which you personally agree or disagree with each statement by placing a mark (/) along the line where your personal rating falls. There is no right or wrong answer. Try to use the whole scale, rather than placing your marks at one end of the line.

I need 8 hours of sleep to feel refreshed and function well during the day.
Strongly disagree _____ Strongly agree

When I don't get a proper amount of sleep on a given night, I need to catch up on the next day by napping or on the next night by sleeping longer.
Strongly disagree _____ Strongly agree

Because I am getting older, I need less sleep.
Strongly disagree _____ Strongly agree

I am worried that if I go for one or two nights without sleep, I may have a nervous breakdown.
Strongly disagree _____ Strongly agree

I am concerned that chronic insomnia may have serious consequences for my physical health.
Strongly disagree _____ Strongly agree

By spending more time in bed, I usually get more sleep and feel better the next day.
Strongly disagree _____ Strongly agree

When I have trouble getting to sleep, I should stay in bed and try harder.
Strongly disagree _____ Strongly agree

I am worried that I may lose control over my abilities to sleep.
Strongly disagree _____ Strongly agree

Because I am getting older, I should go to bed earlier in the evening.
Strongly disagree _____ Strongly agree

After a poor night's sleep, I know that it will interfere with my daily activities on the next day.
Strongly disagree _____ Strongly agree

In order to be alert and function well during the day, I am better off taking a sleeping pill rather than having a poor night's sleep.
Strongly disagree _____ Strongly agree

When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.
Strongly disagree _____ Strongly agree

Because my bed partner falls asleep as soon as his/her head hits the pillow and stays asleep through the night, I should be able to do so too.
Strongly disagree _____ Strongly agree

I feel that insomnia is basically the result of aging, and there isn't much that can be done about this problem.
Strongly disagree _____ Strongly agree

I am sometimes afraid of dying in my sleep.
Strongly disagree _____ Strongly agree

When I have a good night's sleep, I know that I will have to pay for it on the following night.
Strongly disagree _____ Strongly agree

When I sleep poorly on one night, I know it will disturb my sleep schedule for the whole week.
Strongly disagree _____ Strongly agree

Without an adequate night's sleep, I can hardly function the next day.
Strongly disagree _____ Strongly agree

I can't ever predict whether I'll have a good or poor night's sleep.
Strongly disagree _____ Strongly agree

I have little ability to manage the negative consequences of disturbed sleep.
Strongly disagree _____ Strongly agree

When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before.
Strongly disagree _____ Strongly agree

I get overwhelmed by my thoughts at night and often feel I have no control over my racing mind.
Strongly disagree _____ Strongly agree

I feel I can still lead a satisfactory life despite sleep difficulties.
Strongly disagree _____ Strongly agree

I believe insomnia is essentially the result of a chemical imbalance.
Strongly disagree _____ Strongly agree

I feel insomnia is ruining my ability to enjoy life and prevents me from doing what I want.
Strongly disagree _____ Strongly agree

I avoid or cancel obligations (social, family, occupational) after a poor night's sleep.
Strongly disagree _____ Strongly agree

A "nightcap" before bedtime is a good solution to sleep problems.
Strongly disagree _____ Strongly agree

Medication is probably the only solution to sleeplessness.
Strongly disagree _____ Strongly agree

My sleep is getting worse all the time, and I don't believe anyone can help.
Strongly disagree _____ Strongly agree

It usually shows in my physical appearance when I haven't slept well.
Strongly disagree _____ Strongly agree

Insomnia Treatment Acceptability Scale

Two commonly used treatment methods for insomnia problems are described. Please read the description of each method and answer each question as it applies to your insomnia problem. For each question, place a mark (/) along the continuous line where your personal rating falls. Please consider the line to represent your own personal range. Try to use the whole scale, rather than putting your marks at one end or the other.

Treatment 1: Behavioral Treatment

This is a non-drug treatment method aimed at teaching patients self-management skills to overcome insomnia. The behavioral component provides specific guidelines for changing poor sleep habits and for regulating sleep schedules. Patients are also guided to examine and modify their beliefs and attitudes about sleep that may perpetuate their insomnia. Education about sleep hygiene factors (e.g., diet, exercise, and substance use) is also provided. (Please complete all your ratings for this treatment method before proceeding to read the description of the second treatment method.)

How acceptable would you consider this treatment for your insomnia?

Not at all acceptable _____ Very acceptable

How acceptable would you consider this treatment for other people with insomnia?

Not at all acceptable _____ Very acceptable

How willing would you be to adhere to this treatment regimen if recommended for your insomnia?

Not at all willing _____ Very willing

How suitable do you think this treatment would be for treating:

- Difficulty falling asleep at bedtime?

Not at all suitable _____ Very suitable

- Difficulty staying asleep during the night?

Not at all suitable _____ Very suitable

How effective do you believe this treatment would be in the short term?

Not at all effective _____ Very effective

How effective do you believe this treatment would be for producing long-term effects?

Not at all effective _____ Very effective

In addition to improving sleep, how effective would this treatment be for improving other aspects of your daytime functioning (e.g., alertness, performance, mood)?

Not at all effective _____ Very effective

To what extent would this treatment produce side effects?

Very strong side effects _____ No side effects

Treatment 2: Pharmacologic Treatment

This drug treatment consists of taking a prescribed sleeping pill at bedtime. The prescribed hypnotic medication is specifically designed to produce a state of relaxation by reducing physiological (muscular) and cognitive (mental) arousal at bedtime. This medication also increases the threshold for awakening at night and makes patients less sensitive to factors that usually wake them up at night. The specific type of medication and dosage would be based on the nature and severity of the insomnia problem.

How acceptable would you consider this treatment for your insomnia?

Not at all acceptable _____ Very acceptable

How acceptable would you consider this treatment for other people with insomnia?

Not at all acceptable _____ Very acceptable

How willing would you be to adhere to this treatment regimen if recommended for your insomnia?

Not at all willing _____ Very willing

How suitable do you think this treatment would be for treating:

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Very strong side effects _____ No side effects

Significant Other Questionnaire

Name of Patient: _____

Name of Significant Other: _____

Relationship to Patient:

- Spouse/Partner
- Child – Adult
- Child – Minor (age: _____)
- Roommate/Housemate
- Other: _____

Check any of the following behaviors that you have observed the patient doing *while asleep*:

- Light snoring
- Loud snoring
- Pauses in breathing
- Snorting, choking, gasping
- Grinding teeth
- Sleep talking
- Sleep walking
- Bed-wetting
- Head rocking or banging
- Twitching of legs or feet
- Kicking with legs
- Sitting up in bed not awake
- Biting tongue
- Rigid and/or shakiness

How long have you been aware of the sleep behavior(s) that you checked above?

_____ months _____ years

Describe in more detail, as best you can, the behavior(s) checked above. Include a description of the activity, where possible. Also include the time of night during which the behavior occurs. Indicate the frequency that the behavior occurs throughout the night, and how often (e.g., how many nights per week) the behavior takes place.
