SLEEPMEDIK
Sleep Medicine Clinic

Insomnia Severity Index (ISI) Questionnaire

This questionnaire is designed to assess the nature, severity, and impact of your insomnia. Please answer each question based on your sleep patterns over the past two weeks.

Patient Name _____ **Date** _____

For each item, please write down the number that best describes your experience:

Score:

1. **Difficulty falling asleep:**

None	Mild	Moderate	Severe	Very Severe	
0	1	2	3	4	

2. **Difficulty staying asleep:**

None	Mild	Moderate	Severe	Very Severe	
0	1	2	3	4	

3. **Problems waking up too early:**

None	Mild	Moderate	Severe	Very Severe	
0	1	2	3	4	

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

None	Mild	Moderate	Severe	Very Severe	
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?**

None	Mild	Moderate	Severe	Very Severe	
0	1	2	3	4	

6. **How worried/distressed are you about your current sleep problem?**

None	Mild	Moderate	Severe	Very Severe	
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.)?**

None	Mild	Moderate	Severe	Very Severe	
0	1	2	3	4	

Total:

Scoring Instructions

To score the ISI, sum the scores for all seven items. The total score ranges from 0 to 28.

Interpretation:

0–7	No clinically significant insomnia
8–14	Subthreshold insomnia
15–21	Moderate severity insomnia
22–28	Severe insomnia

Please share the completed form with your sleep specialist for further discussion.