Insomnia Test

Sleep Difficulty:

1. How often do you have difficulty falling asleep at night?

0. Never	1. Rarely (1-2 nights per week)	2. Sometimes (3-4 nights per week)	3. Often (5-6 nights per week)	4. Always
○	○	○	◉	○

2. How long does it typically take you to fall asleep?

0. Less than 15 minutes	1. 15-30 minutes	2. 30-60 minutes	3. More than 60 minutes	4. I don't fall asleep at all
○	○	○	◉	○

3. Do you wake up frequently during the night?

0. Never	1. Rarely (1-2 times per night)	2. Sometimes (3-4 times per night)	3. Often (5-6 times per night)	4. Always
○	○	◉	○	○

4. Do you have difficulty falling back asleep after waking up at night?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	◉	○

5. Do you wake up feeling tired, even after having slept for what should be enough time?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	○	◉

Daytime Symptoms:

1. Do you experience excessive daytime sleepiness or fatigue?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	◉	○

2. Do you have difficulty concentrating or remembering things?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	◉	○

3. Do you feel irritable or moody during the day?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	◉	○

4. Do you have difficulty controlling your emotions?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	◉	○

5. Do you experience headaches, muscle tension, or stomach problems?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	◉	○

Sleep Habits:

1. Do you have a regular sleep schedule?

- ○ Yes
- ◉ No

2. Do you nap frequently during the day?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	◉	○

3. Do you consume caffeine or alcohol before bed?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	◉	○	○	○

4. Do you use electronic devices before bed?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	○	○	◉	○

5. Do you engage in relaxing activities before bed?

0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
○	◉	○	○	○

Scoring:

Each question is scored on a scale of 0 to 4, where:

0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Always

Interpretation:

A total score of:

0-15	16-25	26-35	36-60
Indicates minimal to no concerns regarding insomnia.	Suggests potential for mild insomnia symptoms. Consider exploring self-help strategies and improving sleep hygiene.	Indicates moderate concerns regarding insomnia. Seeking professional guidance is recommended.	Suggests significant insomnia symptoms and potential need for intensive therapy and treatment.