## **Insomnia Test**

## **Sleep Difficulty:**

1. How often do yo	ou have difficulty fallir	ng asleep at night?		
$\bigcirc$	$\bigcirc$	$\circ$	$\bigcirc$	$\bigcirc$
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 i	t typically take you to	fall asleep?		
$\circ$	$\circ$	$\circ$	$\circ$	$\circ$
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?		
$\bigcirc$	$\circ$	$\circ$	$\circ$	$\bigcirc$
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 diff	iculty falling back asl	eep after waking up	at night?	
$\circ$	$\bigcirc$	$\circ$	$\bigcirc$	$\bigcirc$
0. Never	1. Rarely	2. Sometimes	3. Often	4. Always
5. Do you wake up	feeling tired, even aft	er having slept for v	vhat should be enou	ugh time?
$\bigcirc$	$\circ$	$\bigcirc$	$\circ$	$\circ$
0. Never	1. Rarely	2. Sometimes	3. Often	4. Always

## **Daytime Symptoms:**

1. Do you experience excessive daytime sleepiness or fatigue?					
$\circ$	$\circ$	$\bigcirc$	$\bigcirc$		
0.	1.	2.	3.	4.	
Never	Rarely	Sometimes	Often	Always	
2. Do you have diffic	culty concentrating	or remembering things	s?		
$\bigcirc$	$\bigcirc$	$\circ$	$\bigcirc$	$\bigcirc$	
0.	1.	2.	3.	4.	
Never	Rarely	Sometimes	Often	Always	
3. Do you feel irritab	le or moody during	the day?			
$\circ$	$\bigcirc$	$\bigcirc$	$\bigcirc$	$\bigcirc$	
0.	1.	2.	3.	4.	
Never	Rarely	Sometimes	Often	Always	
4. Do you have diffic	culty controlling you	ur emotions?			
$\bigcirc$	$\bigcirc$	$\circ$	$\bigcirc$	$\bigcirc$	
0.	1.	2.	3.	4.	
Never	Rarely	Sometimes	Often	Always	
5. Do you experience	e headaches, musc	cle tension, or stomach	problems?		
$\bigcirc$	$\bigcirc$	$\circ$	$\bigcirc$	$\bigcirc$	
0.	1.	2.	3.	4.	
Never	Rarely	Sometimes	Often	Always	
Sleep Habits:					
1. Do you have a reg	jular sleep schedul	e?			
Yes					
○ No					

2. Do you nap frequently	during the da	ay?		
$\bigcirc$	$\bigcirc$		$\circ$	$\circ$
0.	1.	2.	3.	4.
Never	Rarely	Sometimes	Often	Always
3. Do you consume caffe	eine or alcoho	ol before bed?		
$\circ$	$\bigcirc$	$\circ$	$\circ$	$\circ$
0.	1.	2.	3.	4.
Never	Rarely	Sometimes	Often	Always
4. Do you use electronic	devices befo	re bed?		
	$\bigcirc$		$\circ$	$\bigcirc$
0.	1.	2.	3.	4.
Never	Rarely	Sometimes	Often	Always
5. Do you engage in rela	xing activities	s before bed?		
$\bigcirc$		$\circ$	$\bigcirc$	$\bigcirc$
0.	1.	2.	3.	4.
Never	Rarely	Sometimes	Often	Always
Scoring:				
Each question is scored or	n a scale of 0	to 4, where:		
0 = Never 1 = Rarely	2 = So	metimes 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.