



## QUESTIONNAIRE FOR INSOMNIA PATIENTS

NAME : \_\_\_\_\_

DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ GENDER:  Male  Female

**INSOMNIA**

1. How long has insomnia been a problem for you? \_\_\_\_\_
2. Did the onset of your insomnia follow a specific event?  Yes  No  
If yes, please describe.
3. Is this still an ongoing issue for you?  Yes  No  
If yes, please describe.
4. On average, does it take you 30 or more minutes to fall asleep?  Yes  No  
If yes, how many days per week? \_\_\_\_\_
5. On average, do you spend 30 or more minutes awake over the course of the night?  Yes  No  
If yes, how many days per week? \_\_\_\_\_
6. On average, do you wake up before you intend to in the morning?  Yes  No  
If yes, how many days per week? \_\_\_\_\_
7. What aspects of your life and functioning would be improved if your sleep problem suddenly resolved?

8. As the insomnia got worse, did you deal with your fatigue (or catch up for lost sleep) by:

	Yes	No
Going to bed earlier?		
Sleeping in?		
Regularly napping during the day?		
Increased use of stimulants such as caffeine or pills?		
Avoid or decrease physical activity?		
Engage in non-sleep behaviors in the bedroom (e.g., watch TV, read books, etc.) to "kill time?"		
Sleep somewhere other than your bedroom?		
Engage in "rituals" which are thought to promote sleep (e.g., use of special herbs, teas, etc.)?		
Avoid behaviors thought to inhibit sleep (e.g., sex, going outdoors near bedtime)?		
Increase use of alcohol near bedtime?		
Use marijuana?		
Use over-the-counter sedatives?		
Use melatonin?		
Use prescribed sleep medicines?		

9. Describe the last hour of your day.

10. Do you sleep better in a place other than your bedroom (e.g., couch, when traveling, etc.)?  Yes  No

11. What treatments or therapies have you tried for your insomnia? What has and has not helped?

**PRE-SLEEP AROUSAL SCALE**

During the pre-sleep period last night (in bed with the lights out before falling asleep for the first time), did you have any of the following experiences? Do not include what you experienced during the middle of the night if you awakened after falling asleep.

	Not at all	A little	Moderately	A lot	Extremely
Worry about falling asleep					
Worry about problems other than sleep					
Review or ponder events of the day					
Can't shut off your thoughts					
Depressing or anxious thoughts					
Distracted by sounds, noise in the environment (e.g. ticking clock, house noises, traffic)					
A jittery, nervous feeling in your body					
Dry feeling in mouth or throat					
Heart racing, pounding or beating irregularly					
Shortness of breath or labored breathing					
Have stomach upset (knot or nervous feeling in stomach, heartburn, nausea, gas, etc.)					
Cold feeling in your hands, feet or body in general					
Perspiration in palms of your hands or other parts of your body					
A tight, tense feeling in your muscles					
Drum your fingers or tap your feet					

### **BELIEFS AND ATTITUDES ABOUT SLEEP**

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate the extent to which you personally agree or disagree with each statement. There is no right or wrong answer.

Strongly Disagree											Strongly Agree
0	1	2	3	4	5	6	7	8	9	10	

1. I need 8 hours of sleep to feel refreshed and function well during the day.

0	1	2	3	4	5	6	7	8	9	10
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2. 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.

0	1	2	3	4	5	6	7	8	9	10
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3. By spending more time in bed, I usually get more sleep and feel better the next day.

0	1	2	3	4	5	6	7	8	9	10
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4. When I have trouble falling asleep or getting back to sleep after nighttime awakening, I should stay in bed and try harder.

0	1	2	3	4	5	6	7	8	9	10
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5. In order to be alert and function well during the day, I believe I would be better off taking a sleeping pill rather than having a poor night's sleep.

0	1	2	3	4	5	6	7	8	9	10
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6. A "nightcap" before bedtime is a good solution to sleep problems.

0	1	2	3	4	5	6	7	8	9	10
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7. 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.

0	1	2	3	4	5	6	7	8	9	10
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8. Because I am getting older, I need less sleep.

0	1	2	3	4	5	6	7	8	9	10
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9. Because I am getting older, I should go to bed earlier in the evening.

0	1	2	3	4	5	6	7	8	9	10
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10. I feel that insomnia is basically the results of aging and there isn't much that can be done about this problem.

0	1	2	3	4	5	6	7	8	9	10
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11. I am worried that if I go for 1 or 2 nights without sleep, I may have a “nervous breakdown.”

0	1	2	3	4	5	6	7	8	9	10
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12. I am concerned that chronic insomnia may have serious consequences for my physical health.

0	1	2	3	4	5	6	7	8	9	10
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13. When I feel irritable, depressed or anxious during the day, it is mostly because I did not sleep well the night before.

0	1	2	3	4	5	6	7	8	9	10
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14. 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.

0	1	2	3	4	5	6	7	8	9	10
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15. I have little ability to manage the negative consequences of disturbed sleep.

0	1	2	3	4	5	6	7	8	9	10
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16. When I have a good night’s sleep, I know that I will have to pay for it on the following night.

0	1	2	3	4	5	6	7	8	9	10
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17. When I sleep poorly on one night, I know it will disturb my sleep schedule for the whole week.

0	1	2	3	4	5	6	7	8	9	10
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18. I can’t ever predict whether I’ll have a good or poor night’s sleep.

0	1	2	3	4	5	6	7	8	9	10
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19. I get overwhelmed by my thoughts at night and often feel I have no control over this racing mind.

0	1	2	3	4	5	6	7	8	9	10
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20. My sleep is getting worse all the time and I don’t believe anyone can help.

0	1	2	3	4	5	6	7	8	9	10
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21. I feel insomnia is ruining my ability to enjoy life and prevents me from doing what I want.

0	1	2	3	4	5	6	7	8	9	10
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22. I avoid or cancel obligations (social, family) after a poor night’s sleep.

0	1	2	3	4	5	6	7	8	9	10
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## MOOD INVENTORY

Depression not only has a direct effect on sleep but can also sap motivation for change, making compliance with treatment recommendations much more difficult. Before treating your insomnia, treatment of your depression may be necessary.

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past week. Circle the appropriate number for each statement.

Make a check mark in the appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue.	1	2	3	4
2. Morning is when I feel the best.	4	3	2	1
3. I have crying spells or feel like it.	1	2	3	4
4. I have trouble sleeping at night.	1	2	3	4
5. I eat as much as I used to.	4	3	2	1
6. I still enjoy sex.	4	3	2	1
7. I notice that I am losing weight.	1	2	3	4
8. I have trouble with constipation.	1	2	3	4
9. My heart beats faster than usual.	1	2	3	4
10. I get tired for no reason.	1	2	3	4
11. My mind is as clear as it used to be.	4	3	2	1
12. I find it easy to do the things I used to.	4	3	2	1
13. I am restless and can't keep still.	1	2	3	4
14. I feel hopeful about the future.	4	3	2	1
15. I am more irritable than usual.	1	2	3	4
16. I find it easy to make decisions.	4	3	2	1
17. I feel that I am useful and needed.	4	3	2	1
18. My life is pretty full.	4	3	2	1
19. I feel that others would be better off if I were dead.	1	2	3	4
20. I still enjoy the things I used to do.	4	3	2	1
Total Score:				
1. I feel more nervous and anxious than usual.	1	2	3	4
2. I feel afraid for no reason at all.	1	2	3	4
3. I get upset easily or feel panicky.	1	2	3	4
4. I feel like I'm falling apart and going to pieces.	1	2	3	4
5. I feel that everything is all right and nothing bad will happen.	4	3	2	1
6. My arms and legs shake and tremble.	1	2	3	4
7. I am bothered by headaches neck and back pain.	1	2	3	4
8. I feel weak and get easily tired.	1	2	3	4
9. I feel calm and can sit still easily.	4	3	2	1
10. I can feel my heart beating fast.	1	2	3	4
11. I am bothered by dizzy spells.	1	2	3	4
12. I have fainting spells or feel like it.	1	2	3	4
13. I can breathe in and out easily.	4	3	2	1
14. I get feelings of numbness and tingling in my fingers & toes.	1	2	3	4
15. I am bothered by stomach aches or indigestion.	1	2	3	4
16. I have to empty my bladder often.	1	2	3	4
17. My hands are usually dry and warm.	4	3	2	1
18. My face gets hot and blushes.	1	2	3	4
19. I fall asleep easily and get a good night's rest.	4	3	2	1
20. I have nightmares.	1	2	3	4
Total Score:				

## SLEEP DIARY INSTRUCTIONS

Many people with insomnia believe that their sleep is totally random. However, most insomniacs have some residual sleep/wake pattern. This pattern may be hard to see from a night-to-night vantage point, but it will come into focus if you track your sleep over a string of nights.

1. Complete the top half of the diary immediately prior to going to bed.
2. Complete the bottom half immediately upon awakening.
3. **Time to bed** and **Time out of bed** should be recorded by looking at a clock. For the other recordings, do not log your sleep and awakenings across the night by looking at a clock. This effort will only lead you to become more aware of time passing and very likely make it harder for you to sleep. In the morning, just make your best guess as to when sleep and wakefulness occurred.
4. All other recordings should be done in minutes.
 

1 hour = 60 minutes	4 hours = 240 minutes	7 hours = 420 minutes
1.5 hours = 90 minutes	4.5 hours = 270 minutes	7.5 hours = 450 minutes
2 hours = 120 minutes	5 hours = 300 minutes	8 hours = 480 minutes
2.5 hours = 150 minutes	5.5 hours = 330 minutes	8.5 hours = 510 minutes
3 hours = 180 minutes	6 hours = 360 minutes	
3.5 hours = 210 minutes	6.5 hours = 390 minutes	
5. Leave the shaded areas to be calculated with the doctor in clinic.

NAME \_\_\_\_\_  
 DATE \_\_\_\_\_

SLEEP DIARY FOR CBT  
 WEEK \_\_\_\_\_

COMPLETE IMMEDIATELY PRIOR TO BED REGARDING HOW YOU FELT TODAY:

	Day: 1	2	3	4	5	6	7	MEAN
Type of day (Work, School, Vacation)								
Naps (time/amount)								
Time spent exercising (time/amount)								
Time spent outside today (time/amount)								
# Alcoholic beverages (time/amount)								
Sleep medicines today (time/amount)								
Fatigue (None 0-1-2-3-4-5 A lot)								
Stress (None 0-1-2-3-4-5 A lot)								
Alertness (Not very 0-1-2-3-4-5 Very)								
Concentration (Poor 0-1-2-3-4-5 Good)								
Mood (Bad 0-1-2-3-4-5 Good)								
Pain today (None 0-1-2-3-4-5 A lot)								
Health (Felt fine 0-1-2-3-4-5 Bad)								
Menstruate today (Yes/No)								
Menstrual pain (Felt fine 0-1-2-3-4-5 Bad)								

COMPLETE IMMEDIATELY UPON AWAKENING:

	Day: 1	2	3	4	5	6	7	MEAN
Time to bed (clock time)								
Time out of bed (clock time)								
SL: Time to fall asleep (min)								
NOA: Number times awakened (#)								
WASO: Amount of time awake (min)								
TOB: Total time out of bed (min)								
TTA: Total time awake = SL + WASO								
TIB: Time in bed (min) = clock time - TOB								
TST: Total sleep time (min) = TIB - TTA								
SE: Sleep efficiency (%) = TST/TIB x 100								
How well you slept compared to past month*								
How refreshing or restorative**								

\*1. Much worse than average 2. Slightly worse 3. Fairly typical for me 4. Slightly better than average 5. Much better than average  
 \*\*1. Not at all restorative 2. Some slight restorative value 3. Restorative, but not adequately 4. Relatively satisfactory 5. Very satisfactory