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Initial Sleep Disorder Treatment Form

Name: _____ **Date:** ___/___/_____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the scale below to choose the most appropriate number for each situation. Write the numbers on each line and add them up on the total line.

Scale for chance of dozing; *0* = never; *1* = slight; *2* = moderate; *3* = high.

Situation*	Chance of Dozing
Sitting and reading	_____
Watching television	_____
Sitting, inactive a public place (e.g. a theater, meeting)	_____
Sitting as a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
Sitting in a car while stopped for a few minutes in traffic	_____
	Total = _____

*The number for the eight situations are added together to give a global score between 0 and 24.

The Fatigue Severity Scale

How fatigued are you? This questionnaire refers to your usual way of life in recent times. The following nine situations are designed to rate the severity and impact of fatigue or physical tiredness on your life. Use the scale below to agree or disagree with the statements. Circle a number for each statement and add them up on the total line. Thank you for your help with this.

During the past week or so, I have found that:	Disagree ← → Agree
My motivation is lower when I am fatigued.	*1 2 3 4 5 6 7*
Exercise brings on my fatigue.	*1 2 3 4 5 6 7*
I am easily fatigued.	*1 2 3 4 5 6 7*
Fatigue interferes with my physical functioning.	*1 2 3 4 5 6 7*
Fatigue causes frequent problems for me.	*1 2 3 4 5 6 7*
My fatigue prevents sustained physical functioning.	*1 2 3 4 5 6 7*
Fatigue interferes with carrying out certain responsibilities.	*1 2 3 4 5 6 7*
Fatigue is among my three most disabling symptoms.	*1 2 3 4 5 6 7*
Fatigue interferes with my work, family, or social life.	*1 2 3 4 5 6 7*
	Total=_____

*The number for the nine situations are added together to give a global score between 9 and 63.

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Insomnia Severity Index

Please answer each of the questions below by circling the number that best describes your sleep patterns. Please answer all questions.

1. Please rate the current (last 2 weeks) **SEVERITY** of your insomnia problem(s):

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep:	0	1	2	3	4
Difficulty staying asleep:	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

2. How **SATISFIED/DISSATISFIED** are you with your current sleep pattern?

Very Satisfied				Very Dissatisfied
0	1	2	3	4

3. 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 Interfering	A little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

4. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all Noticeable	A little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

5. How **WORRIED/DISTRESSED** are you about your current sleep problem?

Not at all	A little	Somewhat	Much	Very Much
0	1	2	3	4

Total =_____