Name:_____

Sleep Impairment Index

1. Please rate the current (last 2 weeks) **severity** of your sleep problems (for all questions rate '0' if your sleep has not been a problem).

	None	mild	moderate	severe	very severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problem waking too early	0	1	2	3	4

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

Very satisfied		moderately satisfied		very dissatisfied
0	1	2	3	4

3. To what extent do you consider problems with sleep **interfere** with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood etc?).

Not at all	a little	somewhat	much	very much
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	a little	somewhat	much	very much
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

Thank you for you time.
This questionnaire will be used to compare your sleep before the program and after.
Please also complete the **7 day sleep log (see website)**.
We look forward to working with you.