

Behavioral Sleep Medicine

Name: _____ **Date:** _____
Occupation: _____ **Education:** _____

Patient Health Questionnaire – 9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

(Circle your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Are you under the care of a mental health professional (e.g., psychiatrist, psychologist) or have you seen one in the past 6 months? YES NO

If yes, please print his/her name and phone number. _____

Have you experienced any major losses or separations that have been particularly distressful in the past 6 months? YES NO

If yes, please specify: _____

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Totals	0			
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Total PHQ-9 score = _____

GAD-7

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

(Circle your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

PROMIS Sleep-Related Impairment Short Form

Over the **last 7 days**, how often have you been bothered by any of the following problems?

(Circle your answer)

	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. I had a hard time getting things done because I was sleepy	1	2	3	4	5
2. I felt alert when I woke up	5	4	3	2	1
3. I felt tired	1	2	3	4	5
4. I had problems during the day because of poor sleep	1	2	3	4	5
5. I had a hard time concentrating because of poor sleep	1	2	3	4	5
6. I felt irritable because of poor sleep	1	2	3	4	5
7. I was sleepy during the daytime	1	2	3	4	5
8. I had trouble staying awake during the day	1	2	3	4	5

Office Use

GAD-7 Totals	0			
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Total GAD-7 score = ____

PROMIS Sleep-Related Impairment SF Total score = ____

Morningness Eveningness Abbreviated Questionnaire

If you had the option, would you rather...

- Get up early and go to bed early
- No specific preference about bedtimes
- Get up late and go to bed late

Insomnia Severity Index (ISI)

(Circle your answer)

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

	None	Mild	Moderate	Severe	Very severe
a. Difficulty falling asleep	0	1	2	3	4
b. Difficulty staying asleep	0	1	2	3	4
c. Problem waking up too early	0	1	2	3	4

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

Very Satisfied	Satisfied	Neutral	Dissatisfied	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 worried	A little	Somewhat	Much	Very much worried
0	1	2	3	4

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ISI Total score = ____