Date:

Name:

Date of Birth:

Hospital Number:

CBT for Insomnia

ASSESSMENT SCALES

1. This bundle of questionnaires is designed to help us assess the severity of your insomnia, its underlying causes and impact on your life. The information will help us offer you the most appropriate treatment.
2. Please note that there are **TEN separate questionnaires** in this bundle. You need to **complete them ALL.**

	Questionnaire	**Score**
1.	Insomnia Severity Index	
2.	DBAS-16	
3.	GAD-7	
4.	Patient Health Questionnaire-9	
5.	Impact of Events Scale (Revised)	
6.	CORE-10	
7.	Epworth Sleepiness Questionnaire	
8.	Flinder's Fatigue Scale	
9.	Toronto Hospital Alertness Test (THAT)	
10.	DCI	

Insomnia Severity Index

For each question below, please circle the number corresponding most accurately to your sleep patterns in the **LAST MONTH**.

For the first three questions, please rate the **SEVERITY** of your sleep difficulties.

1. Difficulty falling asleep:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

2. Difficulty staying asleep:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

3. Problem waking up too early in the morning:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

4. How **SATISFIED**/dissatisfied are you with your current sleep pattern?

Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. 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)?

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

6. 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 Noticeable	Somewhat Noticeable	Very Noticeable	Extremely Noticeable
0	1	2	3	4

7. How **WORRIED**/distressed are you about your current sleep problem?

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

Add your scores for all items – **TOTAL SCORE** =

DBAS-16

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

For each statement, **circle the number** that corresponds to your own personal belief.

Please respond to all items even though some may not apply directly to your own situation.

Strongly disagree	**Example statement:** 0 1 2 3 4 5 6 (7) 8 9 10	**Strongly agree**

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
2	**When I don't get 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
3	**I am concerned that chronic insomnia may have serious consequences on my physical health.**
	0 1 2 3 4 5 6 7 8 9 10
4	**I am worried that I may lose control over my abilities to sleep.**
	0 1 2 3 4 5 6 7 8 9 10
5	**After a poor night's sleep, I know that it will interfere with my daily activities on the next day.**
	0 1 2 3 4 5 6 7 8 9 10
6	**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
7	**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

8	**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	
9	**Without an adequate night's sleep, I can hardly function the next day.**	
	0 1 2 3 4 5 6 7 8 9 10	
10	**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	
11	**I have little ability to manage the negative consequences of disturbed sleep.**	
	0 1 2 3 4 5 6 7 8 9 10	
12	**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	
13	**I believe insomnia is essentially the result of a chemical imbalance.**	
	0 1 2 3 4 5 6 7 8 9 10	
14	**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	
15	**Medication is probably the only solution to sleeplessness.**	
	0 1 2 3 4 5 6 7 8 9 10	
16	**I avoid or cancel obligations (social, family) after a poor night's sleep.**	
	0 1 2 3 4 5 6 7 8 9 10	
Please add your scores for questions 1-16)		

Date:

Name:

DOB:

Hosp No:

GAD – 7 Scale

Over the last week, how often have you been bothered by the following problems?					
		Not at all	Several days	More than half the days	Nearly every day
1.	Feeling nervous, anxious, or on edge. (Aa)	0	1	2	3
2.	Not being able to stop or control worrying.(B)	0	1	2	3
3.	Worrying too much about different things.(Ab)	0	1	2	3
4.	Trouble relaxing.(C5)	0	1	2	3
5.	Being so restless that it is hard to sit still.(C1)	0	1	2	3
6.	Becoming easily annoyed or irritable.(C4)	0	1	2	3
7.	Feeling afraid as if something awful might happen.(Ab)	0	1	2	3
	Add score for each column				
	TOTAL				

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? **Please circle only one.**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Date:	Name:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

(DSM-5: a214637859)

Please circle the answer that fits best for you **based on the LAST TWO WEEKS.**

		Not at all	**Several days**	**More than half the days**	**Nearly every day**
1.	**Little interest or pleasure in doing things (a2).**	**0**	**1**	**2**	**3**
2.	**Feeling down, depressed, or hopeless (a1).**	**0**	**1**	**2**	**3**
3.	Trouble falling or staying asleep, or sleeping too much (a4).	0	1	2	3
4.	Feeling tired or having little energy (a6).	0	1	2	3
5.	Poor appetite or overeating (a3).	0	1	2	3
6.	Feeling bad about yourself or that you are a failure or that you have let yourself or your family down (a7).	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching TV (a8).	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed; (a5) **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 (a9).	0	1	2	3
	Total for column				
	TOTAL				

10.	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
	0	1	2	3

IMPACT OF EVENTS SCALE-6

The following is a list of difficulties people sometimes have after stressful life events.

Please read each item, and then indicate how distressing each difficulty has been for you <u>during the past 7 days</u> with respect to stressful life events.

How much were you distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
I thought about it when I didn't mean to	0	1	2	3	4
Other things kept making me think about it	0	1	2	3	4
I was aware that I still had a lot of feelings about it, but I didn't deal with them	0	1	2	3	4
I tried not to think about it	0	1	2	3	4
I felt watchful or on-guard	0	1	2	3	4
I had trouble concentrating	0	1	2	3	4
Add columns					
TOTAL SCORE					

Clinical Outcomes in Routine Evaluation (CORE-10)

- This questionnaire has 10 statements about how you have been **OVER THE LAST WEEK**
- Please read each statement and think how often you felt that way over the last week
- Then, **please tick (✓) the box which is closest to this**

Instructions for scoring CORE-10

- Before you score the questionnaire, check you have answered all ten questions.
- Each answer has a number next to it between 0 and 4. Simply add up all ten numbers to give you a score between 0 and 40. This is the total score.
- Remember that this is just a snapshot of how things have been in the last week. Your score may vary from week to week in the normal course of events.

Over the last week:	**Not at all**	**Only occasionally**	**Sometimes**	**Often**	**Most of the time**
1. I have felt tense, anxious or nervous.	0	1	2	3	4
2. I have felt I have someone to turn to for support when needed.	4	3	2	1	0
3. I have felt able to cope when things go wrong	4	3	2	1	0
4. Talking to people has felt too much for me.	0	1	2	3	4
5. I have felt panic or terror.	0	1	2	3	4
6. I made plans to end my life.	0	1	2	3	4
7. I have difficulty getting to sleep or staying asleep.	0	1	2	3	4
8. I have felt despairing or hopeless.	0	1	2	3	4
9. I have felt unhappy.	0	1	2	3	4
10. Unwanted images or memories have been distressing me.	0	1	2	3	4
Add columns					
TOTAL SCORE					

EPWORTH SLEEPINESS SCALE

- Please rate how likely you are to sleep in the following situations, **based on your experience in the LAST MONTH**.

- We are **not asking you to rate how tired** you would be in these situations **BUT HOW LIKELY YOU WOULD BE TO ACTUALLY DOZE OFF.**

- If you have not been in the following situations recently, think about how you would have been affected. Circle the most appropriate number for each situation.

		Would Never Doze	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
1	Sitting and reading	0	1	2	3
2	Watching TV	0	1	2	3
3	Sitting Inactive in a Public Place	0	1	2	3
4	As a passenger in a car for an hour	0	1	2	3
5	Lying down to rest in the afternoon	0	1	2	3
6	Sitting and talking to someone	0	1	2	3
7	Sitting quietly after lunch without alcohol	0	1	2	3
8	In a car while stopped in traffic for a few minutes	0	1	2	3
	Add score for columns				
	TOTAL				

Flinder's Fatigue Scale

We are interested in the extent that you have felt **fatigued** (tired, weary, exhausted) over the last **two weeks**. We **do not** mean feelings of **sleepiness** (the likelihood of falling asleep).

Please circle the appropriate response in accordance with your **average feelings over the last week**

		Not at all		**Moderate**		**Extremely**
1.	Was fatigue a problem for you?	0	1	2	3	4
2.	Did fatigue cause problems with your everyday functioning (e.g., work, social, family)?	0	1	2	3	4
3.	Did fatigue cause you distress?	0	1	2	3	4
4.	How severe was the fatigue you experienced?	0	1	2	3	4
5.	How much was your fatigue caused by poor sleep?	0	1	2	3	4
Your total score						

6.	**How often did you suffer from fatigue?**				
	0 Days a week	1-2 days/week	3-4 days/week	5-6 days/week	7 days/week
	0	1	2	3	4
	Score				

7.	**At what times of the day did you typically experience fatigue? If you experience fatigue at different parts of the day, mark ('X') all that apply to you.**		
		Mark with an 'X' all that apply:	Score 1 for each item that applies
	Early morning		
	Mid-morning		
	Midday		
	Mid-afternoon		
	Late afternoon		
	Early evening		
	Late evening		
		Total	

Your total score = [i.e., total for questions 1-5 + score for item 6 + Total for question 7] **=**

Toronto Hospital Alertness Test

Instructions:

- This questionnaire tries to establish **how alert you have felt over the past 7 days**
- **Please select (tick ✓) one response for each question**

During the last 7 days I felt:	Not at all	Less 25% of the time	25-50% of the time	50-75% of the time	More than 75% of the time	All the time I was awake
1. Able to concentrate(0-5)	0	1	2	3	4	5
2. Alert (0-5)	0	1	2	3	4	5
3. Fresh (0-5)	0	1	2	3	4	5
4. Energetic (0-5)	0	1	2	3	4	5
5. Able to think of new ideas (0-5)	0	1	2	3	4	5
6. Vision was clear noting all details (e.g. driving) (0-5)	0	1	2	3	4	5
7. Able to focus on the task at hand (0-5)	0	1	2	3	4	5
8. Mental facilities were operating at peak level (0-5)	0	1	2	3	4	5
9. Extra effort was needed to maintain alertness (5-0	5	4	3	2	1	0
10. In a boring situation I would find my mind wandering (5-0)	5	4	3	2	1	0
Total for column						
Total Score						

Kyle et al. (2013). Sleep Medicine

Please complete the questionnaire to tell us how your **LIFE** is currently affected by your **SLEEP** and how you would like to see it improve.

If you feel that your life is not affected by the way you sleep please tick here ☐

PART 1: List the areas

In your own words, write down the 3 most important things that are affected <u>because</u> of your poor sleep.

Part 2: Ranking

Now rank each box (1,2,3) based on how concerned you are by it i.e. **1** = the thing that concerns you most, **2**= the next area that concerns you most, and **3** = the final area that concerns you least out of the three.

PART 3: Ratings

Now give each of these areas a score, depending upon how <u>bothered</u> you were by it, in the past **<u>two weeks.</u>** Place a vertical mark through the line (┼) wherever your personal rating falls

Here is an example:

Very bothered — *Not bothered*

Very bothered — Not bothered

Very bothered — Not bothered

Very bothered — Not bothered

PART 4: Spend

Finally, imagine you had **£60** to <u>spend</u> trying to get rid of these problems. Divide up your **£60** any way you like. You can spread it around or spend it all on just one or two things.

	Suitability for CBT-I : Is CBT-I suitable for me?			
1.	**If any of the following apply to you, we are unable to offer you CBT-I**		**Yes**	**No**
	Inability /unwillingness to follow the principles of CBT-I			
	Alcohol abuse			
	Substance abuse			
	Undiagnosed or severe medical illness; **severe** ME/chronic fatigue			
	Psychiatric disorders, e.g., Schizophrenia, Bipolar disorder, depression with psychosis			
	Significant personality Disorder			
2.	**The following will make the process of CBT-I difficult and the outcome may not be as good as usual.**		**Yes**	**No**
	Excessive intake of Caffeine containing beverages after mid-day			
	Alcohol intake within 4 hours of your bed time			
	Smoking in the sleep period – Do you smoke after 6 p.m.?			
	Epilepsy; Severe migraine			
	Sleep walking; Sleep terrors			
	ME/Chronic Fatigue Syndrome			
3.	**Is this a good time for starting CBT for Insomnia – consider the following.**		**No**	**Yes**
	Discontinuation of sleeping tablets	Most patients will need to/want to stop sleeping tablets. This will worsen your insomnia. What is your view on that? Are you anxious about stopping your sleeping tablets?		
	Spouse/partner	The partners' sleep could be disrupted during your therapy. Do you have your partner's support?		
	Bedroom/ house	Sometimes it may be better to sleep in another bedroom to avoid disturbing your partner – do you have a spare bedroom?		
	Driving /work	You are likely to feel more sleepy and fatigued in the daytime in the first few weeks. Driving may be hazardous and you may have to refrain from driving. Will that be possible?		
		Feeling worse may affect your work. Do you have the flexibility at work?		
	General life situation	Will you need to engage in any major events in your life such as having to take major financial decisions? Do you anticipate any such events?.		
	Social factors	Do you anticipate any major social or psychological upheaval – e.g., daughter getting married next month??? Does it apply to you?		
	Your holidays	It is unrealistic to continue strict sleep schedules while on holidays. Have you planned any holidays in the next three months?		
	Therapist's holidays	The therapist may go on annual or other leave and you may be left to continue therapy on your own for a period – usually a week, but occasionally 2-3 weeks. Will you be able to do that?		

Insomnia Severity Index

For each question below, please circle the number corresponding most accurately to your sleep patterns in the **LAST MONTH**.

For the first three questions, please rate the **SEVERITY** of your sleep difficulties.

1. Difficulty falling asleep:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

2. Difficulty staying asleep:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

3. Problem waking up too early in the morning:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

4. How **SATISFIED**/dissatisfied are you with your current sleep pattern?

Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. 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)?

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

6. 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 Noticeable	Somewhat Noticeable	Very Noticeable	Extremely Noticeable
0	1	2	3	4

7. How **WORRIED**/distressed are you about your current sleep problem?

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

Add your scores for all items – **TOTAL SCORE** =

DBAS-16

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

For each statement, **circle the number** that corresponds to your own personal belief.

Please respond to all items even though some may not apply directly to your own situation.

Strongly disagree	**Example statement:** 0 1 2 3 4 5 6 (7) 8 9 10	**Strongly agree**

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
2	**When I don't get 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
3	**I am concerned that chronic insomnia may have serious consequences on my physical health.**
	0 1 2 3 4 5 6 7 8 9 10
4	**I am worried that I may lose control over my abilities to sleep.**
	0 1 2 3 4 5 6 7 8 9 10
5	**After a poor night's sleep, I know that it will interfere with my daily activities on the next day.**
	0 1 2 3 4 5 6 7 8 9 10
6	**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
7	**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

8	**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	
9	**Without an adequate night's sleep, I can hardly function the next day.**	
	0 1 2 3 4 5 6 7 8 9 10	
10	**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	
11	**I have little ability to manage the negative consequences of disturbed sleep.**	
	0 1 2 3 4 5 6 7 8 9 10	
12	**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	
13	**I believe insomnia is essentially the result of a chemical imbalance.**	
	0 1 2 3 4 5 6 7 8 9 10	
14	**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	
15	**Medication is probably the only solution to sleeplessness.**	
	0 1 2 3 4 5 6 7 8 9 10	
16	**I avoid or cancel obligations (social, family) after a poor night's sleep.**	
	0 1 2 3 4 5 6 7 8 9 10	
Please add your scores for questions 1-16)		

Date:

Name:

DOB:

Hosp No:

GAD – 7 Scale

Over the last week, how often have you been bothered by the following problems?					
		Not at all	Several days	More than half the days	Nearly every day
1.	Feeling nervous, anxious, or on edge. (Aa)	0	1	2	3
2.	Not being able to stop or control worrying.(B)	0	1	2	3
3.	Worrying too much about different things.(Ab)	0	1	2	3
4.	Trouble relaxing.(C5)	0	1	2	3
5.	Being so restless that it is hard to sit still.(C1)	0	1	2	3
6.	Becoming easily annoyed or irritable.(C4)	0	1	2	3
7.	Feeling afraid as if something awful might happen.(Ab)	0	1	2	3
	Add score for each column				
	TOTAL				

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? **Please circle only one.**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Date:	Name:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

(DSM-5: a214637859)

Please circle the answer that fits best for you **based on the LAST TWO WEEKS.**

		Not at all	**Several days**	**More than half the days**	**Nearly every day**
1.	**Little interest or pleasure in doing things (a2).**	**0**	**1**	**2**	**3**
2.	**Feeling down, depressed, or hopeless (a1).**	**0**	**1**	**2**	**3**
3.	Trouble falling or staying asleep, or sleeping too much (a4).	0	1	2	3
4.	Feeling tired or having little energy (a6).	0	1	2	3
5.	Poor appetite or overeating (a3).	0	1	2	3
6.	Feeling bad about yourself or that you are a failure or that you have let yourself or your family down (a7).	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching TV (a8).	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed; (a5) **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 (a9).	0	1	2	3
	Total for column				
	TOTAL				

10.	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
	0	1	2	3

IMPACT OF EVENTS SCALE-6

The following is a list of difficulties people sometimes have after stressful life events.

Please read each item, and then indicate how distressing each difficulty has been for you <u>during the past 7 days</u> with respect to stressful life events.

How much were you distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
I thought about it when I didn't mean to	0	1	2	3	4
Other things kept making me think about it	0	1	2	3	4
I was aware that I still had a lot of feelings about it, but I didn't deal with them	0	1	2	3	4
I tried not to think about it	0	1	2	3	4
I felt watchful or on-guard	0	1	2	3	4
I had trouble concentrating	0	1	2	3	4
Add columns					
TOTAL SCORE					

Clinical Outcomes in Routine Evaluation (CORE-10)

- This questionnaire has 10 statements about how you have been **OVER THE LAST WEEK**
- Please read each statement and think how often you felt that way over the last week
- Then, **please tick (✓) the box which is closest to this**

Instructions for scoring CORE-10

- Before you score the questionnaire, check you have answered all ten questions.
- Each answer has a number next to it between 0 and 4. Simply add up all ten numbers to give you a score between 0 and 40. This is the total score.
- Remember that this is just a snapshot of how things have been in the last week. Your score may vary from week to week in the normal course of events.

Over the last week:	**Not at all**	**Only occasionally**	**Sometimes**	**Often**	**Most of the time**
1. I have felt tense, anxious or nervous.	0	1	2	3	4
2. I have felt I have someone to turn to for support when needed.	4	3	2	1	0
3. I have felt able to cope when things go wrong	4	3	2	1	0
4. Talking to people has felt too much for me.	0	1	2	3	4
5. I have felt panic or terror.	0	1	2	3	4
6. I made plans to end my life.	0	1	2	3	4
7. I have difficulty getting to sleep or staying asleep.	0	1	2	3	4
8. I have felt despairing or hopeless.	0	1	2	3	4
9. I have felt unhappy.	0	1	2	3	4
10. Unwanted images or memories have been distressing me.	0	1	2	3	4
Add columns					
TOTAL SCORE					

EPWORTH SLEEPINESS SCALE

- Please rate how likely you are to sleep in the following situations, **based on your experience in the LAST MONTH**.

- We are **not asking you to rate how tired** you would be in these situations **BUT HOW LIKELY YOU WOULD BE TO ACTUALLY DOZE OFF.**

- If you have not been in the following situations recently, think about how you would have been affected. Circle the most appropriate number for each situation.

		Would Never Doze	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
1	Sitting and reading	0	1	2	3
2	Watching TV	0	1	2	3
3	Sitting Inactive in a Public Place	0	1	2	3
4	As a passenger in a car for an hour	0	1	2	3
5	Lying down to rest in the afternoon	0	1	2	3
6	Sitting and talking to someone	0	1	2	3
7	Sitting quietly after lunch without alcohol	0	1	2	3
8	In a car while stopped in traffic for a few minutes	0	1	2	3
	Add score for columns				
	TOTAL				

Flinder's Fatigue Scale

We are interested in the extent that you have felt **fatigued** (tired, weary, exhausted) over the last **two weeks**. We **do not** mean feelings of **sleepiness** (the likelihood of falling asleep).

Please circle the appropriate response in accordance with your **average feelings over the last week**

		Not at all		**Moderate**		**Extremely**
1.	Was fatigue a problem for you?	0	1	2	3	4
2.	Did fatigue cause problems with your everyday functioning (e.g., work, social, family)?	0	1	2	3	4
3.	Did fatigue cause you distress?	0	1	2	3	4
4.	How severe was the fatigue you experienced?	0	1	2	3	4
5.	How much was your fatigue caused by poor sleep?	0	1	2	3	4
Your total score						

6.	**How often did you suffer from fatigue?**				
	0 Days a week	1-2 days/week	3-4 days/week	5-6 days/week	7 days/week
	0	1	2	3	4
	Score				

7.	**At what times of the day did you typically experience fatigue? If you experience fatigue at different parts of the day, mark ('X') all that apply to you.**		
		Mark with an 'X' all that apply:	Score 1 for each item that applies
	Early morning		
	Mid-morning		
	Midday		
	Mid-afternoon		
	Late afternoon		
	Early evening		
	Late evening		
		Total	
Your total score = [i.e., total for questions 1-5 + score for item 6 + Total for question 7] **=**			

Toronto Hospital Alertness Test

Instructions:

- This questionnaire tries to establish **how alert you have felt over the past 7 days**
- **Please select (tick ✓) one response for each question**

During the last 7 days I felt:	Not at all	Less 25% of the time	25-50% of the time	50-75% of the time	More than 75% of the time	All the time I was awake
1. Able to concentrate(0-5)	0	1	2	3	4	5
2. Alert (0-5)	0	1	2	3	4	5
3. Fresh (0-5)	0	1	2	3	4	5
4. Energetic (0-5)	0	1	2	3	4	5
5. Able to think of new ideas (0-5)	0	1	2	3	4	5
6. Vision was clear noting all details (e.g. driving) (0-5)	0	1	2	3	4	5
7. Able to focus on the task at hand (0-5)	0	1	2	3	4	5
8. Mental facilities were operating at peak level (0-5)	0	1	2	3	4	5
9. Extra effort was needed to maintain alertness (5-0	5	4	3	2	1	0
10. In a boring situation I would find my mind wandering (5-0)	5	4	3	2	1	0
Total for column						
Total Score						

DCI					
Please indicate if you suffer from any of the issues below. If so, how severe is the problem?					
		None	**Mild**	**Moderate**	**Severe**
		0	**1**	**2**	**3**
1.	Fatigue				
2.	Daytime sleepiness				
3.	Reduced alertness in the day				
4.	Poor attention				
5.	Poor concentration				
6.	Poor memory				
7.	Mood disturbance				
8.	Irritability				
9.	Poor motivation				
10.	Lack of energy				
11.	Lack of initiative				
12.	Making errors in day-to-day affairs				
13.	Accidents at home, on the road or at work				
14.	Hyperactivity				
15.	Impulsivity				
16.	Aggressiveness				
	Subtotal				
	TOTAL				

Kyle et al. (2013). Sleep Medicine

Please complete the questionnaire to tell us how your **LIFE** is currently affected by your **SLEEP** and how you would like to see it improve.

If you feel that your life is not affected by the way you sleep please tick here ☐

PART 1: List the areas

In your own words, write down the 3 most important things that are affected <u>because</u> of your poor sleep.

Part 2: Ranking

Now rank each box (1,2,3) based on how concerned you are by it i.e. **1** = the thing that concerns you most, **2**= the next area that concerns you most, and **3** = the final area that concerns you least out of the three.

PART 3: Ratings

Now give each of these areas a score, depending upon how <u>bothered</u> you were by it, in the past **<u>two weeks.</u>** Place a vertical mark through the line (┼) wherever your personal rating falls

Here is an example:

Very bothered — *Not bothered*

Very bothered — Not bothered

Very bothered — Not bothered

Very bothered — Not bothered

PART 4: Spend

Finally, imagine you had **£60** to <u>spend</u> trying to get rid of these problems. Divide up your **£60** any way you like. You can spread it around or spend it all on just one or two things.