

PSSQ_I

ID _____

Date ____ / ____ / ____
 m m / d d / y y

Instructions: Below is a list of common sleep complaints. During the past month, how many nights or days per week have you had, or been told you had, the following symptoms? If you have experienced any of these symptoms please indicate how long it has lasted in weeks, months or years.

During the past month . . .	Never	Do not know	Rarely less than once per week	Sometimes 1-2 times per week	Frequently 3-4 times per week	Always 5-7 times per week	How long has the symptom lasted? (# of weeks, months or years)
1. Difficulty falling asleep.	0	1	2	3	4	5	<input type="checkbox"/> wks <input type="checkbox"/> mos <input type="checkbox"/> yrs _____
2. Difficulty staying asleep.	0	1	2	3	4	5	<input type="checkbox"/> wks <input type="checkbox"/> mos <input type="checkbox"/> yrs _____
3. Frequent awakenings from sleep.	0	1	2	3	4	5	<input type="checkbox"/> wks <input type="checkbox"/> mos <input type="checkbox"/> yrs _____
4. Feeling that your sleep is not sound.	0	1	2	3	4	5	<input type="checkbox"/> wks <input type="checkbox"/> mos <input type="checkbox"/> yrs _____
5. Feeling that your sleep is unrefreshing.	0	1	2	3	4	5	<input type="checkbox"/> wks <input type="checkbox"/> mos <input type="checkbox"/> yrs _____

If you checked "never"
 or "do not know" for **all**
of these symptoms
 YOU MAY STOP.

If you checked "rarely" to
 "always" for **any of these**
symptoms please continue
 with questions 6-13.

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Instructions: If you have experienced **any** sleep symptoms **during the past month** please circle the appropriate number to let us know how your sleep is affecting your daily life.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
6. How much do your sleep problems bother you?	0	1	2	3	4
7. Have your sleep difficulties affected your work?	0	1	2	3	4
8. Have your sleep difficulties affected your social life?	0	1	2	3	4
9. Have your sleep difficulties affected other important parts of your life?	0	1	2	3	4
10. Have your sleep difficulties made you feel irritable?	0	1	2	3	4
11. Have your sleep problems caused you to have trouble concentrating?	0	1	2	3	4
12. Have your sleep difficulties made you feel fatigued?	0	1	2	3	4
13. How sleepy do you feel during the day?	0	1	2	3	4