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**	☐ **wks** ☐ **mos** ____ ☐ **yrs**
2. Difficulty staying asleep.	0	1	**2**	**3**	**4**	**5**	☐ **wks** ☐ **mos** ____ ☐ **yrs**
3. Frequent awakenings from sleep.	0	1	**2**	**3**	**4**	**5**	☐ **wks** ☐ **mos** ____ ☐ **yrs**
4. Feeling that your sleep is not sound.	0	1	**2**	**3**	**4**	**5**	☐ **wks** ☐ **mos** ____ ☐ **yrs**
5. Feeling that your sleep is unrefreshing.	0	1	**2**	**3**	**4**	**5**	☐ **wks** ☐ **mos** ____ ☐ **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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ID ___ ___ ___ ___ ___ ___

Date ___ ___ / ___ ___ / ___ ___
m m d d y y

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