Insomnia Disorder

1. **Over the past 3 months or longer, have you had persistent difficulty with the amount or quality of your sleep that has caused you significant distress or interfered with your ability to function during the day?** **A** ☒ **P**

2. **Do you frequently have difficulty with:**
   - ❑ **Falling asleep (i.e., taking longer than 30 minutes)**
   - ❑ **Staying asleep (e.g., frequently waking up in the middle of the night, difficulty returning to sleep after waking up during the night)**
   - ❑ **Waking up early in the morning and being unable to return to sleep**

   [AT LEAST ONE #2 ITEM IS CHECKED] **A** ☒ **P**

3. **On average, how many nights per week do you experience this sleep problem?** _____

   [SLEEP DIFFICULTY OCCURS AT LEAST 3 NIGHTS PER WEEK] **A** ☒ **P**

4. **How long have you been experiencing this sleep problem?** _____

5. **Does this sleep problem continue even when you give yourself enough time to get a good sleep?** **A** ☒ **P**

6. [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] **A** ☒ **S** ☒ **P**

   Is it very upsetting for you that you have these symptoms?

   Have the symptoms interfered with your ability to carry out daily activities? In what ways have they interfered? Do you experience daytime fatigue? Have they made it hard for you to work, socialize, go to school, or take care of things at home? Has it resulted in significant changes to your behaviours?

[NOTES:]

7. [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY OR DO NOT OCCUR EXCLUSIVELY DURING THE COURSE OF ANOTHER SLEEP-WAKE DISORDER (E.G., NARCOLEPSY, A BREATHING-RELATED DISORDER, A CIRCADIAN RHYTHM SLEEP-WAKE DISORDER, A PARASOMNIA). IF NOT KNOWN, QUERY ABOUT ALTERNATIVE SLEEP DISORDERS OR DETERMINE IF ADDITIONAL ASSESSMENT MAY BE REQUIRED, OR ASK:] **A** ☒ **P**

   Have you ever had a sleep study and/or been diagnosed with another sleep-wake disorder?

		A	P
8.	[THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE. IF NOT KNOWN, ASK:] Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse?	☒	
9.	[THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY A CO-OCCURRING MENTAL DISORDER OR MEDICAL CONDITION, OR THEY ARE SEVERE AND REQUIRE SPECIFIC CLINICAL ATTENTION]	☒	
10.	[DURATION OF SLEEP PROBLEM IS AT LEAST 3 MONTHS]		

DIAGNOSTIC IMPRESSION:

	A	S	P
DURATION OF SLEEP PROBLEM IS ≥ 3 MONTHS: INSOMNIA DISORDER			
DURATION OF SLEEP PROBLEM IS < 3 MONTHS: OTHER SPECIFIED SLEEP DISORDER	☒		

[SPECIFY:]

[SPECIFY ASSOCIATED MENTAL DISORDER (INCLUDES SUBSTANCE USE DISORDERS):] _____ WITH NON-SLEEP DISORDER MENTAL COMORBIDITY ❒

[SPECIFY ASSOCIATED MEDICAL CONDITION:] _____ WITH OTHER MEDICAL COMORBIDITY ❒

[SPECIFY OTHER SLEEP DISORDER:] _____ WITH OTHER SLEEP DISORDER ❒

[FOR INSOMNIA DISORDER, SPECIFY:]

SYMPTOMS LAST ≥ 3 MONTHS — PERSISTENT ❒

TWO OR MORE EPISODES WITHIN 1 YEAR — RECURRENT ❒

[FOR OTHER SPECIFIED SLEEP DISORDER, SPECIFY:]

SYMPTOMS LAST BETWEEN 1 AND 3 MONTHS — EPISODIC ❒

[SPECIFY:]

PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER — WITH PANIC ATTACKS ❒

[NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK, SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE]

11. **How old were you when these symptoms first began?** _____

12. **How old were you when these symptoms began to be a problem for you?** _____

13. **In your life, how many separate episodes, similar to the one that we just discussed, have you experienced in the past?** _____

14. **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** _____