Name: _____ Date of Birth: _____ Today's Date: _____

Epworth Sleepiness Scale:

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:
0 = would *never* doze or sleep
1 = *slight* chance of dozing or sleeping
2 = *moderate* change of dozing or sleeping
3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping _____
Sitting and reading	
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total Score (add the scores up)	
This is your Epworth Score	_____

Adapted from Johns, M. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. *Sleep*, 14, 540-545

The Insomnia Severity Index

Please rate the current (i.e., last two weeks) severity of your insomnia problem(s).

	None	***Mild***	***Moderate***	***Severe***	***Very Severe***
Difficulty falling asleep:	0	1	2	3	4
Difficulty staying asleep:	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

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

Very satisfied	**Satisfied**	**Neutral**	**Dissatisfied**	**Very dissatisfied**
0	1	2	3	4

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

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

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

Flinders 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 this two-week period.

Name: _____ Date: _____

1. Was fatigue a problem for you?

☐	☐	☐	☐	☐
Not at all		Moderately		Extremely

2. Did fatigue cause problems with your everyday functioning (e.g., work, social, family)?

☐	☐	☐	☐	☐
Not at all		Moderately		Extremely

3. Did fatigue cause you distress?

☐	☐	☐	☐	☐
Not at all		Moderately		Extremely

4. How often did you suffer from fatigue?

☐	☐	☐	☐	☐
0 days/week	1-2 days/week	3-4 days/week	5-6 days/week	7 days/week

5. At what time(s) of the day did you typically experience fatigue? (Please tick box(es))

Early Morning	☐	Late Afternoon	☐
Mid Morning	☐	Early Evening	☐
Midday	☐	Late Evening	☐
Early Afternoon	☐		

6. How severe was the fatigue you experienced?

☐	☐	☐	☐	☐
Not at all		Moderately		Extreme

7. How much was your fatigue caused by poor sleep?

☐	☐	☐	☐	☐
Not at all		Moderately		Entirely

DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3, which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3