Please complete this form and show it to your doctor or other healthcare professional.

Do you have Insomnia?

1. Do you have problems falling asleep, staying asleep, or having restful sleep? YES NO
2. Have you been experiencing these sleep problems for at least one month? YES NO
3. Are your sleep problems solely due to another medical condition (e.g. sleep apnea)? YES NO
4. Are your sleep problems solely due to a medication, drug/alcohol use, or excessive caffeine use? YES NO
5. Do your sleep problems, including feeling tired during the day, cause you significant problems in your life (e.g. problems at work, school, with family/friends)? YES NO

You might have Insomnia if all of the following are true:

- You answered YES to questions 1, 2, and 5
- You answered NO to questions 3 and 4

Note: This questionnaire is for informational purposes only and is not intended to function as a psychological or psychiatric assessment. Diagnosis of psychiatric disorders requires a careful evaluation by a trained professional.

To get help for this condition or to receive a comprehensive assessment, please call The Institute of Living's Anxiety Disorders Center at (860) 545-7685.