Western Washington Medical Group

Cognitive Behavioral Therapy for Insomnia

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Greetings!

You are invited to return to our clinic to discuss Cognitive Behavioral Therapy for Insomnia (CBT-I). Prior to your return, I would like to give you a bit more information about what is involved and to ask you to complete some questionnaires that will make our first visit more efficient.

CBT-I is a type of therapy designed specifically to help people who have difficulty falling and/or staying asleep. Most people experience acute (or short-lived) episodes of difficulty sleeping. However, for some people, those acute episodes of sleeplessness can turn into an ongoing problem (or chronic problem). CBT-I is based on the premise that behavioral and physical factors play a role in continuing insomnia. This is where we aim our efforts. We will work together to identify changes you can make which will help promote better quality sleep.

Typically, I will meet with you 6-8 times over 2-3 months while we work to improve your sleep. At each visit, you will bring me data, in the form of sleep diaries, which we use to tailor a plan specific to you. We will try to accomplish our goals without the use of medication. Sleep research shows the benefits of sleep medication are not long lasting and CBT-I offers more benefit to people in the long run.

Attached you will find a packet of questionnaires, aimed to find out more about your sleep and behaviors. I would greatly appreciate it if you brought this to our first visit. We will review them together and discuss your responses. You will also have the opportunity to ask any questions you have about the questionnaires and CBT-I.

I look forward to meeting you and am excited about your interest in CBT-I.

Sincerely,

Jessica Webb, ARNP

Insomnia History Form

Subject ID# _____ Date: _____

1.) How old were you when you first starting experiencing insomnia? _____

2.) How many years ago did you start experiencing insomnia? _____

3.) How old were you when the insomnia became chronic? _____

4.) How long have you had insomnia? _____

5.) Since you have been experiencing insomnia have there been any periods of time that you have not had insomnia for 2 or more weeks at a time?

_____

_____

_____

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep 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

6. 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

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Sleep Environment Questionnaire

1. **I use an alarm clock five or more days a week.**

____True ____ False ____ Not Applicable

2. **I keep the temperature in the bedroom so cold that I have 2 or more blankets on the bed to stay warm at night.**

____True ____ False ____ Not Applicable

3. **The blinds and curtains in the bedroom are so effective that at sunrise the room is so dark its hard to tell that the sun came up.**

____True ____ False ____ Not Applicable

4. **I have spent real time and money making sure that my mattress and pillow are perfect for me.**

____True ____ False ____ Not Applicable

5. **During the night, my bedroom is insulated so well that I rarely if ever hear outside noise from the road, neighbors, etc.**

____True ____ False ____ Not Applicable

6. **House noise from the radiators, floor boards, etc. is so minimal that I am rarely aware of such sounds.**

____True ____ False ____ Not Applicable

7. **My home is a safe place. My partner and/or pet and/or the locks and alarm system and/or concern and support of my neighbors provide me a level of comfort such that I rarely if ever worry about being safe at night.**

____True ____ False ____ Not Applicable

8. **On three or more nights per week, I engage in two or more of the following behaviors in the bedroom: watch TV, read, plan, worry, work, clean, or eat.**

____True ____ False ____ Not Applicable

9. **My pets rarely, if ever, keep me from falling asleep or wake me up during the night.**

____True ____ False ____ Not Applicable

10. **My bed partner's sleep schedule or habits while in bed (reading, moving about, stealing the covers, snoring, etc.) rarely, if ever, disturb my sleep.**

____True ____ False ____ Not Applicable

11. **My child's/children's sleep schedule or habits while in bed or during the night rarely if ever disturb my sleep.**

____True ____ False ____ Not Applicable

SDS-CL-25 (V4)

Date: ___/___/___ ID/Initials ____ Age: ___ Sex: __ Height _____ Weight _____ Work Shift: __ n/a __ First (9-5pm) __ Second (4-12am) __ Third (12to 8am) Work Hours: __ 0 __ 10-20 __ 20-40 or ___ > 40 Hours per week Do you regularly have a bed partner? (3 or more days/week) ___ (Yes/No) How much sleep do you typically get per night? ____ hours (e.g., 8.5 hours) How much time to you typically spend in bed per night? ___ hours (e.g., 9.5 hours) **Answer all questions for what has been typical for you for the last 3 months.**	NEVER	ONCE A MONTH	1-3 TIMES A WEEK	3-5 TIMES A WEEK	>5 TIMES A WEEK
1. My work or other activities prevent me from getting at least 6hrs of sleep					
2. My bedtime or waketime varies by more than 3 hours					
3. It takes me 30 minutes or more to fall asleep					
4. I am awake for 30 minutes or more during the night					
5. I wake up 30 or more minutes before I have to and can't fall back asleep					
6. I am tired, fatigued, or sleepy during the day					
7. I sleep better if I go to bed before 9pm and wake up before 430am					
8. I sleep better if I go to bed late (after 1am) and wakeup late (after 9am)					
9. I am prone to fall asleep at inappropriate times or places					
10. I snore					
11. I wake up with a dry mouth in the morning (cotton mouth)					
12. My snoring is so loud, that my bed partner complains					
13. I have been told that that I stop breathing in my sleep					
14. I wake up choking or gasping for air					
15. I feel uncomfortable sensations in my legs, especially when sitting or lying down, that are relieved by moving them					
16. I have an urge to move my legs that is worse in the evenings and nights					
17. I wake up frequently during the night for no reason					
18. When angered, humored, frightened, I experience sudden muscle weakness					
19. When falling asleep or waking up, I experience scary dream like images					
20. When I am first awakening, I feel like I can't move					
21. I have nightmares					
22. For no reason, I awaken suddenly, feeling startled and afraid					
23. I have been told that I walk, talk, eat, act strangely or violently while asleep					
24. I grind my teeth or clench my jaw while I sleep					
25. My sleep difficulties interfere with my daily activities					

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column		+	+	+
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.