KAIROS SLEEP CLINIC EPWORTH SLEEPINESS SCALE (ESS)

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Epworth Sleepiness Scale (ESS)

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

Use the following scale to rate each situation:

0 = Would never doze | 1 = Slight chance of dozing | 2 = Moderate chance of dozing | 3 = High chance of dozing

1. Sitting and reading	0 ☐	1 ☐	2 ☐	3 ☐
2. Watching TV	0 ☐	1 ☐	2 ☐	3 ☐
3. Sitting, inactive in a public place (e.g., a theater or a meeting)	0 ☐	1 ☐	2 ☐	3 ☐
4. As a passenger in a car for an hour without a break	0 ☐	1 ☐	2 ☐	3 ☐
5. Lying down to rest in the afternoon when circumstances permit	0 ☐	1 ☐	2 ☐	3 ☐
6. Sitting and talking to someone	0 ☐	1 ☐	2 ☐	3 ☐
7. Sitting quietly after a lunch without alcohol	0 ☐	1 ☐	2 ☐	3 ☐
8. In a car, while stopped for a few minutes in traffic	0 ☐	1 ☐	2 ☐	3 ☐

Total ESS Score: _____

KAIROS SLEEP CLINIC INSOMNIA SEVERITY INDEX (ISI)

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Insomnia Severity Index (ISI)

Please rate the severity of your insomnia symptoms over the past 2 weeks:

1. Rate the severity of your insomnia symptoms:

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 ☐

2. How satisfied/dissatisfied are you with your current sleep pattern? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

3. To what extent do you consider your sleep problem to interfere with your daily functioning? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

4. How noticeable to others do you think your sleep problem is in terms of impairing quality of life? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

5. How worried/distressed are you about your current sleep problem? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

Total ISI Score: _____

KAIROS SLEEP CLINIC PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Use the following scale to rate each statement:

0 = Not at all | 1 = Several days | 2 = More than half the days | 3 = 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 fidgety 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 in some way	0 ☐	1 ☐	2 ☐	3 ☐

Total PHQ-9 Score: _____