MISSION PSYCHIATRY

Insomnia Self-Assessment

Think about your recent sleep patterns and select the response that best describes how often you experience each difficulty.

Question	Not at all	Several days	More than half the days	Nearly every day
1. Do you have difficulty falling asleep when you go to bed?				
2. Do you wake up during the night and have difficulty getting back to sleep?				
3. Do you wake up earlier than you would like and have difficulty falling back asleep?				
4. Do you feel that your sleep is not restful or refreshing, even when you have had enough opportunity to sleep?				
5. Do you spend a significant amount of time worrying about whether you will be able to sleep?				
6. Do you find yourself thinking about problems, responsibilities, or other concerns when you are trying to fall asleep?				
7. Do you feel tired, sleepy, or lacking energy during the day because of poor sleep?				
8. Do sleep difficulties affect your concentration, memory, mood, or ability to stay focused during the day?				
9. Do you feel irritable, frustrated, or emotionally affected because of your sleep difficulties?				
10. Do you avoid activities, change your schedule, or limit your plans because of concerns about your sleep or daytime fatigue?				
11. Have your sleep difficulties continued despite having a reasonable opportunity and environment to sleep?				
12. Do your sleep difficulties interfere with your work, school, relationships, or everyday responsibilities?				

Important Disclaimer: This self-assessment provided by Mission Psychiatry is intended for informational and educational purposes only. It is not a diagnostic test and does not diagnose insomnia or any other sleep or mental health condition. Your results are meant to serve as a helpful guide and starting point for discussion, not as an official diagnosis. Only a qualified healthcare professional can provide a diagnosis after a comprehensive evaluation.