The CogSleep Screener – Patient Version

The following questions relate to your usual sleep habits over the <u>last week</u>.		
1	What time do you typically go to bed at night?	**Time…………. pm**
2	What time do you typically wake up in the morning?	**Time…………. am**
3	On average, how long does it take for you to fall asleep?	**…….…...… mins**

The next questions relate to your sleep quality over the <u>last week</u>. Please circle the number of nights/days you experienced the following:

4. Taking more than 30-minutes to fall asleep at night?

0	1	2	3	4	5	6	7

5. Waking during the night and finding it difficult to fall asleep again?

0	1	2	3	4	5	6	7

6. Waking up too early in the morning and not being able to fall asleep again?

0	1	2	3	4	5	6	7

7. Having vivid dreams, or acting out your dreams (e.g., punching, kicking, screaming)?

0	1	2	3	4	5	6	7

8. Experiencing nightmares or frightening dreams?

0	1	2	3	4	5	6	7

9. Feeling overly sleepy during the day?

0	1	2	3	4	5	6	7

10. Napping during the day?

0	1	2	3	4	5	6	7

Scoring (office use only):

Domain	Calculation	Cut-score*	Above threshold?
Insomnia	Qs (4 + 5 + 6)/ 3	1.5	Y/N
Rapid Eye Movement Symptoms	Qs (7 + 8)/ 2	0.25	Y/N
Daytime sleepiness	Qs (9 + 10)/ 2	0.25	Y/N

* Scores above the cut-score indicate the presence of insomnia/rapid eye movement symptoms/daytime sleepiness

CogSleep Screener Version 1: *Kong, Menczel Schrire, Lin, Simonetti, Cross, Mowszowski, Ireland, Rosenzweig & Naismith*. 2023