CogSleep Screener

	Please answer the following questions relating to your sleep over the ***last week****:*	
1	Was the past week a routine week (e.g., no jetlag/travel, shift work, traumatic or stressful events) for you?	Yes / No
2	What time did you typically go to bed at night?	Time: ……… pm/am
3	What time did you typically wake up in the morning?	Time: ……… am/pm
4	On average, how long did it take for you to fall asleep?	………. mins
5	How many hours of *actual* sleep did you get at night? (this may be different than the number of hours you spent in bed).	………. hours
6	How would you rate your sleep quality overall? 1. Very Bad 2. Fairly Bad 3. Fair 4. Fairly Good 5. Very Good	
7	Did your sleep quality impact your daytime functioning?	Yes / No
	Over the ***last week****, did you experience the following at least once (≥1) during the day or night?*	
8	Taking more than 30-minutes to fall asleep at night?	Yes / No
9	Waking during the night and finding it difficult to fall asleep again?	Yes / No
10	Waking up too early in the morning and not being able to fall asleep again?	Yes / No
11	Have you ever been told, or suspected yourself, that you seem to ‘act out your dreams’ while asleep (for example, punching, flailing your arms in the air, making running movements, etc.)?”	Yes / No
12	Feeling overly sleepy during the day?	Yes / No
13	Napping for more than 10 minutes during the day/early evening?	Yes / No
14	Snoring, snorting or gasping for air?	Yes / No
15	Uncomfortable sensations in your legs such as crawling, tingling, or itching sensations, that disrupt your ability to fall asleep?	Yes / No
16	Do you wake up at about the same time (within one hour) every day?	Yes / No
	Over the ***last year****, did you experience the following at least once (>1) during the day or night?*	
17	Have you experienced sleep walking/talking, or leaving the bed and engaging in any unusual activities whilst sleeping, which you may not fully remember when awake?	Yes / No
18	Had **violent** dreams during which you might have inadvertently (almost) hurt yourself or your bed partner?	Yes / No

Version 1.3 - revised from Version 1 (Kong et al., 2025)

COGSLEEP
Centre of Research Excellence for Optimising Sleep in Brain Ageing and Neurodegeneration

Scoring (office use only):

Domain	Calculation[1]	Cut-score[2]	Above threshold?
Insomnia	Qs (8 + 9 + 10)/ 3	1.5	Y/N
Daytime sleepiness	Qs (12 + 13)/ 2	0.25	Y/N

1 Yes = 1 point; No = 0 point

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