# APPENDIX 2. ASSESSMENT TOOLS

## 2a) Sleep assessment tool

**ALL INFORMATION PROVIDED IS TREATED AS CONFIDENTIAL**

|  |
| --- |
| **Name:**………………………………………………………………………………**Tel No:**…………………………………………..**Date of birth:**…………………… |

**About your sleep**

How many hours sleep do you get each night?

|  |  |  |  |
| --- | --- | --- | --- |
| Less than 2 hours | 2–4 hours | 4–6 hours | 6 or more hours |

During the last month how many times have you felt refreshed when you wake up in the morning?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

During a typical month do you get good quality deep sleep, or is your mind still alert during sleep?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Always good quality | Mostly good quality | Equal amount of good and poor quality | Mostly poor quality | Always poor quality |

During the last month how often have you had difficulty sleeping because:

a. You could not get to sleep within 30 minutes?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

b. You wake up in the middle of the night or early morning?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

c. You have to get up to use the bathroom?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

d. You snore, gasp for air, or stop breathing?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

e. You kick or thrash about while asleep?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

f. You are in pain?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

g. The room is too light, noisy, hot or cold?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

Please list any other reasons:

………………………………………………………………………………………………

How often did these reasons affect your sleep in the last month?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

How many times during the last month have you had difficulty staying awake whilst driving, eating or engaging in social activity?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

How often do you sleep during the day?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

During the last month have you taken any stimulants (e.g. nicotine, caffeine, amphetamine, decongestants) after 6 pm?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

Are you taking any other medicines? Please list:

………………………………………………………………………………………………

**About your sleep medication**

How long have you been taking benzodiazepines or z-drugs?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 2 months or less | 2–6 months | 6–12 months | 1–5 years | More than 5 yrs |

During the last month how often have you taken benzodiazepines or z-drugs?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

Do you take any additional remedies to help you sleep (e.g. NytolTM, herbal remedies, alcohol)? Please list:

 …………………………………………………………………………..

During the last month how often have you taken an additional remedy?

|  |  |  |  |
| --- | --- | --- | --- |
| Not in the last month | Less than once a week | Once or twice a week | Three or more times a week |

## 2b) Sleep condition indicator (SCI)

|  |  |
| --- | --- |
| **Item** | **Score** |
| 4 | 3 | 2 | 1 | 0 |
| ***Thinking about a typical night in the last month…*** |
| 1…..how long does it take you to fall asleep? | 0–15 min | 16–30 min | 31–45 min | 46–60 min | ≥ 61 min |
| 2….if you then wake up during the night, how long are you awake for in total (add all the wakenings up) | 0–15 min | 16–30 min | 31–45 min | 46–60 min | ≥ 61 min |
| 3….how many nights a week do you have a problem with your sleep? | 0–1 | 2 | 3 | 4 | 5–7 |
| 4….how would you rate your sleep quality? | Very good | Good | Average | Poor | Very poor |
| ***Thinking about the past month, to what extent has poor sleep…*** |
| 5….affected your mood, energy, or relationships? | Not at all | A little | Some-what | Much | Very much |
| 6….affected your concentration, productivity, or ability to stay awake? | Not at all | A little | Some-what | Much | Very much |
| 7….troubled you in general? | Not at all | A little | Some-what | Much | Very much |
| **Finally…** |
| 8….how long have you had a problem with your sleep? | I don’t have a problem/ < 1 mo | 1–2 mo | 3–6 mo | 7–12 mo | > 1 year |

**Scoring instructions:**

* Add the item scores to obtain the SCI total (minimum 0, maximum 32)
* A higher score means better sleep
* Scores can be converted to 0–10 format (minimum 0, maximum 10) by dividing total by 3.2
* Items scores in grey area represent threshold criteria for Insomnia Disorder[[1]](#footnote-1)

## 2c) Generalised anxiety disorder assessment (GAD 7)

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

**Scoring instructions:**

Scores of 5, 10 and 15 are taken as the cut-off points for mild, moderate and severe anxiety respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.[[2]](#footnote-2)

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 people?

|  |  |  |  |
| --- | --- | --- | --- |
| **Not difficult at all** | **Somewhat difficult** | **Very difficult** | **Extremely difficult** |
| [ ] | [ ] | [ ] | [ ] |

For information on diagnosis of anxiety and depression please refer to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The NICE guideline on Generalised anxiety disorder and panic disorder in adults, adopted the DSM diagnostic criteria, and used this definition when considering their treatment recommendations.

## 2d) Sleep diary

**INSTRUCTIONS – Keep diary for 2 weeks**

1. Write the date and type of day: **W**ork, **D**ay **O**ff, **H**oliday
2. Put the letter ‘**C**’ in the box when you have coffee, tea or cola. Put ‘**M**’ when you take any medicine. Put ‘**A**’ when you drink alcohol. Put ‘**E**’ when you exercise.
3. Put a line (**\**) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you have a nap during the day.
5. Leave boxes un-shaded to show when you wake up at night and when you are awake during the day.

***Sample entry below:*** *On Monday when I was in work, I jogged on my lunch break at 1pm, had a glass of wine with dinner at 6pm, fell asleep watching TV from 7 to 8pm, went to bed at 10pm, fell asleep around 11pm, woke up and couldn’t go back to sleep at about 4am, went back to sleep from 5 to 7am, and had a coffee and medicine at 7am.[[3]](#footnote-3)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Day | 12pm | 1pm | 2pm | 3pm | 4pm | 5pm | 6pm | 7pm | 8pm | 9pm | 10pm | 11pm | 12am | 1am | 2am | 3am | 4am | 5am | 6am | 7am | 8am | 9am | 10am | 11am |
| Example | W |  | E |  |  |  |  | A |  |  |  | \ |  |  |  |  |  |  |  |  | C M |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Day | 12pm | 1pm | 2pm | 3pm | 4pm | 5pm | 6pm | 7pm | 8pm | 9pm | 10pm | 11pm | 12am | 1am | 2am | 3am | 4am | 5am | 6am | 7am | 8am | 9am | 10am | 11am |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

## 2e) Anxiety diary

Use this diary to keep a note of when and where you feel anxious. You only need to make a brief entry, and record how anxious you are feeling using the anxiety scale. The scale is marked from 1 to 10; 1 indicates you are very slightly anxious, 5 is moderately anxious, and 10 is extremely anxious, or the most anxious you’ve ever been.

Filling in the chart will help figure out the cause of your anxiety, and whether there are specific times of the day or week that relate to more severe anxiety episodes. This will help us choose the best way to deal with your anxiety problem.

**Your name** …………………………………………………………………………………….

|  |  |  |  |
| --- | --- | --- | --- |
| **Day, date and time** | **Where are you?** | **What are you doing?** | **Anxiety scale**  |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

1. Source: Espie CA, Kyle SD, Hames P, *et al*. The Sleep Condition Indicator: a clinical screening tool to evaluate insomnia disorder. *BMJ Open.* 2014;4:e004183 [↑](#footnote-ref-1)
2. Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A Brief Measure for Assessing Generalized Anxiety Disorder. *Arch Intern Med.* 2006;166:1092-1097. [↑](#footnote-ref-2)
3. Source: American Academy of Sleep Medicine. Sleep Diary [www.sleepeducation.org/docs/default-document-library/sleep-diary.pdf?sfvrsn=2](http://www.sleepeducation.org/docs/default-document-library/sleep-diary.pdf?sfvrsn=2) [↑](#footnote-ref-3)