Athens Sleep Questionnaire (ASQ)

Instructions

This scale is intended to record your own assessment of any **sleep difficulty** you might have experienced.

Please check the items below to indicate your estimate of any difficulty, provided that it occurred at least **three times per week** during the **last month**.

1 Sleep induction (time it takes you to fall asleep after turning-off the lights)

0	1	2	3
No problem	Slightly delayed	Markedly delayed	Very delayed or did not sleep at all

2 Awakenings during the night

0	1	2	3
No problem	Minor problem	Considerable problem	Serious problem or did not sleep at all

3 Final awakening earlier than desired

0	1	2	3
Not earlier	A little earlier	Markedly earlier	Much earlier or did not sleep at all

4 Total sleep duration

0	1	2	3
Sufficient	Slightly insufficient	Markedly insufficient	Very insufficient or did not sleep at all

5 Overall quality of sleep (no matter how long you slept)

0	1	2	3
Satisfactory	Slightly unsatisfactory	Markedly unsatisfactory	Very unsatisfactory or did not sleep at all

6 Sense of well-being during the day

0	1	2	3
Normal	Slightly decreased	Markedly decreased	Very decreased

7 Functioning (physical and mental) during the day

0	1	2	3
Normal	Slightly decreased	Markedly decreased	Very decreased

8 Sleepiness during the day

0	1	2	3
None	Mild	Considerable	Intense

Source: Soldatos, C. R., Dikeos, D.G., & Paparrigopoulos, T.J. (2000)
Athens insomnia scale: validation of an instrument based on ICD-10 criteria. Journal of Psychosomatic Research 48(6)555–560

Add the scores for all 8 items: **Total score** ____

When the values total a score equal or greater than **6** is indicative of insomnia.

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