THE TINNITUS INTERVIEW

Name:

DOB:

AHC:

Referred By:

Phone: **Email:**

Address:

Date:

1. Introduction

We would like to gather some general information about the Tinnitus so that we can understand the specific ways that you are impacted by tinnitus. If you would like more room to explain, please write on the back of the form. We will have the opportunity to discuss things in more detail when we meet. We would like to begin by asking you:

How would you describe the tinnitus?

What does it sound like? Is there more than one sound?
Circle all that apply:

ringing	hissing sizzling	clicking
clear tone	buzzing	electric fan
pulsating	roaring	pounding
hum	cicadas	crickets
whistle	music	bells
others (describe)		

Has the sound changed over time?

2. Duration of the tinnitus?

For how long have you been aware of the tinnitus?
Can you recall the first time that you noticed the tinnitus?
When did the tinnitus become a significant problem, one that caused a great deal of annoyance?
What percentage of the time do you think about the tinnitus?

3. Features of the tinnitus

Where does it seem to be located? (eg:, left/right ear, both ears, inside head, outside head)
How loud is it, typically on a scale of 1-10 (10 being extremely loud)
How loud is it right now?
How loud is it when it is at its loudest?
Does anything appear to make it louder?
Does anything appear to make it quieter?
Has the overall loudness changed over time?
Have there ever been periods when the tinnitus has disappeared altogether?
How would you describe the “pitch” (base or treble) of the Tinnitus?
Does it change in pitch?

4. Sleeping Difficulties

Does the tinnitus make it difficult for you to fall asleep?
How many nights per week/month?
How long does it normally take you to fall asleep?
How long did it take to fall asleep before you had tinnitus?
Do you sleep through the night?
If you wake up, how long does it take to fall asleep?
Do you feel rested when you wake up?
What thoughts and emotions do you have about tinnitus and sleep?
Have you had sleep difficulties before you developed Tinnitus?

5. Impact of the tinnitus on daily life

Tinnitus can affect daily life in many ways:

Physically:
Please circle the physical symptoms you experience since the tinnitus

Fatigue/loss of energy
Loss of appetite/increased appetite
Weight loss/gain
Headaches
Muscle Tension
Insomnia
Neck/Back Pain
Jaw Pain
Ear pain
Other _____

Emotionally:
Please circle the emotions you have felt since the tinnitus.

Depression anger resentment irritability anxiety fear distress panic hopelessness helplessness frustration worry grief reactions isolation inadequate loneliness guilt worthlessness confused
other_____

Occupationally:
Please circle the ways your work is affected since the tinnitus.

Increased stress due to change in work status
Change in ability to function in current position
Financial strain
Blame or resentment about exposure to noise or unknown 'triggers that may have caused it
Other _____

Cognitively:
Please circle the ways your mental functioning have been affected since the tinnitus.

Difficulties in concentrating
Problems with decision-making
Over-analyzing
Distracted, unable to focus
Other _____

Socially:
Please circle the ways your relationships and activities have been affected since the tinnitus.

Loss of interest or pleasure in activities
Less involvement with others
Increased conflict in relationships
Increased communication problems
Increased isolation and 'avoidance'
Increased sleep or 'self-medicating'
Other _____

6. Suicidal Ideation

Have you ever felt so bad that you think you would harm yourself/don't want to live any more?

If yes:
How often do you have thoughts like that?
Have you had these thoughts lately?

When was the last time that you had these thoughts?
Have you felt like this in the last week?
What, specifically, have you thought about doing to yourself?

Have you ever attempted to harm yourself in the past?

If YES, when did this take place, the circumstances that led up to it and what were the nature of the actions
If NO: What has stopped you from carrying out your plans?
Do you think you will really do it? How likely is it that you will actually do it?

8. Tinnitus and Stress

Does your tinnitus get louder when you are under stress?

What sort of stress makes it more difficult to manage?

Do you have more difficulty managing the tinnitus when you are under stress?

Aside from the tinnitus, what are the other major stressors in your life?

Have you ever experienced as traumatic event?

9. Social

Do you know of anyone else who experiences tinnitus?

How often do you talk to others about your tinnitus?

To whom? What is their reaction? How does that make you feel?

Do you call upon other people to assist you in any way because of the tinnitus?

In what ways (if any) does the tinnitus affect your social life?

How (if at all) has your tinnitus affected your relationships with those people who are most important to you?

10. Interference/Avoidance

Do you believe that your leisure or work activities are affected by the tinnitus?

List activities that have been disrupted:

Do you ever avoid activities or situations because of the tinnitus?

List situations:

Does the tinnitus lead you to avoid noisy places?
List places or situations:

Does the tinnitus lead you to avoid quiet places?
List places or situations:

In what ways, if any, do you think you have changed since you began to have this problem?

11. Cognitive

Are you aware of any particular 'negative ' thoughts that you have when the tinnitus is loud or bothersome?

Example: I can't stand this, why did this happen to me, no one understands etc.

Please list the most frequent things you say to yourself about the tinnitus and list the beliefs you have about the tinnitus

12. Treatment History

Primary Care Physician Dr. _____

Contact Number:

Significant health history:

Current Medical Conditions:

Have you had any accidents, injuries or trauma involving the head or neck that may be relevant to the tinnitus?

Dates:

List recent surgeries and date:

Otolaryngologist (ENT):

Name

Date seen:

Recommendations:

Were you sent for a CT scan or MRI?

Date:

What was the outcome?

Audiology:

When and where was your last audiological and ear examination?

Do you know if you have any hearing problems, other than Tinnitus?

Name of audiologist/hearing clinic:

Do you wear hearing aids?

Have you ever tried masking or sound therapy as a treatment for tinnitus?
Describe:

Have you had any experience with Tinnitus Retraining Therapy (TRT)? Describe

Psycho-Social:
Have you ever seen a counselor, psychologist, psychiatrist, or health professional for treatment of psychological problems?

When and for what concerns?

How was it helpful?

What was least helpful?

Have you experience with relaxation training or similar procedures?
Describe:

Have you experience with biofeedback? Describe:

Please circle the **Complementary Therapies** you have tried:

Meditation, acupuncture, herbal medicines, supplements, naturopathic or homeopathic remedies, other_____

Describe what was helpful:

Vestibular/Balance Issues:

Is the tinnitus ever accompanied by dizziness, nausea or vomiting?

Do you notice that the tinnitus changes with certain head positions or eye movements?

Have you been evaluated by a **Vestibular Physiotherapist?**

When? Name of Physio:

Dental:

Do you know if you have any dental problems? Do you get pain or clicking in the jaw?

Do you grind your teeth at night or clench?

Have you been evaluated by a dentist for TMJ?

When? **Name of Dentist:**

How often do you have a headache? (frequency, symptoms, locations, possible triggers, etc.)

Medications:
List all current medication, dosage and when it was prescribed:

Are you taking any medications specifically for symptoms that accompany the tinnitus? (anxiety, insomnia, depression)

Other treatments:
Please describe any other treatment approaches you have tried or are currently doing:

13. Expectations about treatment

It is important that expectations regarding treatment are realistic. As research continues to search for a cure, the current therapies and approaches are designed to 'manage' the impact of tinnitus. Though the features of the sound itself may not change (pitch, volume, frequency), there are many methods that can facilitate improved management of tinnitus impact.

What do you know about the management tools available for people with tinnitus?

Though we understand that the hope is that treatment could eliminate the sound, however, that is not surgically or pharmaceutically possible at this time. Even if the sound does not change, would you be motivated to learn researched techniques that are designed to reduce tinnitus related distress and manage the impact of tinnitus in your life?

The enclosed article on "The Role of the Psychologist in the Management of Tinnitus" will help you understand more clearly how you can achieve this and improve the quality of your life.

With this understanding what are your hopes and expectations regarding tinnitus management?

14. Other Relevant Information

Is there anything else that you think we should know in order to have a better understanding of the tinnitus and how it affects you?

Is there anything else that might be relevant?

We greatly appreciate the time you have taken to answer these questions. The information you have provided helps us to create a management plan and make recommendations specifically for you.

Tinnitus Handicap Inventory **Name:** **Date:**

Instructions to patients: The purpose of the scale is to identify the problems your tinnitus may be causing you. Circle "yes," "sometimes," or "no" for each question.

Item*	Patient response		
1F. Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
2F. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3E. Does your tinnitus make you angry?	Yes	Sometimes	No
4F. Does your tinnitus make you feel confused?	Yes	Sometimes	No
5C. Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
6E. Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7F. Because of your tinnitus, do you have trouble falling asleep at night?	Yes	Sometimes	No
8C. Do you feel as thought you can't escape your tinnitus?	Yes	Sometimes	No
9F. Does your tinnitus interfere with your ability to enjoy social activities?(Such as going to dinner or to the movies?)	Yes	Sometimes	No
10E. Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11C. Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
12F. Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13F. Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14F. Because of your tinnitus, do you find that you are often irritable?	Yes	Sometimes	No
15F. Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16E. Does your tinnitus make you upset?	Yes	Sometimes	No
17E. Do you feel that your tinnitus problem has placed stress on your relationship with members of your family and friends?	Yes	Sometimes	No
18F. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
19C. Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20F. Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21E. Because of your tinnitus, do you feel depressed?	Yes	Sometimes	No
22E. Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23C. Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24F. Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25E. Does your tinnitus make you feel insecure?	Yes	Sometimes	No

*F= an item contained on the functional subscale; E= an item contained on the emotional subscale; C= an item contained on the catastrophic response subscale.

Source: From: Newman CW, Jacobson GP, Spitzer JB. Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head and Neck Surgery 122: 143-149, 1996. Reprinted with permission.

SCORING YOUR TEST: GIVE A VALUE OF "4" TO ALL QUESTIONS ANSWERED "YES"
GIVE A VALUE OF "2" TO ALL QUESTIONS ANSWERED "NO"

TOTAL = _____

Level 1 = Slight (0-16) Level 2 = Mild (18-36) Level 3 = Moderate (38-56) Level 4 = Severe (58-76)

Level 4 = Severe (58-76) Level 5 = Catastrophic (78-100)

Name: _____ Date: _____

TINNITUS REACTION QUESTIONNAIRE

This questionnaire is designed to find out what sort of effects tinnitus has on your emotions, lifestyle, and general well being. Some of the effects listed here may well apply to you; others may not. Please be sure that you answer each question by circling the number that best reflects how your tinnitus has affected you over the past week.

0 = Not at all 1= A little 2=Sometimes 3 = Often 4=Almost Always

1. My tinnitus has made me unhappy. 0 1 2 3 4
2. My tinnitus has made me feel tense. 0 1 2 3 4
3. My tinnitus has made me feel irritable. 0 1 2 3 4
4. My tinnitus has made me feel angry. 0 1 2 3 4
5. My tinnitus has led me to cry. 0 1 2 3 4
6. My tinnitus has led me to avoid quiet situations. 0 1 2 3 4
7. My tinnitus has made me feel less interested in going out. 0 1 2 3 4
8. My tinnitus has made me feel depressed. 0 1 2 3 4
9. My tinnitus has made me feel annoyed. 0 1 2 3 4
10. My tinnitus has made me feel confused. 0 1 2 3 4
11. My tinnitus has “driven me crazy.” 0 1 2 3 4
12. My tinnitus has interfered with my enjoyment in life. 0 1 2 3 4
13. My tinnitus has made it hard for me to concentrate. 0 1 2 3 4
14. My tinnitus has made it hard for me to relax. 0 1 2 3 4
15. My tinnitus has made me feel distressed. 0 1 2 3 4
16. My tinnitus has made me feel helpless. 0 1 2 3 4
17. My tinnitus has made me feel frustrated with things. 0 1 2 3 4
18. My tinnitus has interfered with my ability to work. 0 1 2 3 4
19. My tinnitus has led me to despair. 0 1 2 3 4
20. My tinnitus has led me to avoid noisy situations. 0 1 2 3 4
21. My tinnitus has led me to avoid social situations. 0 1 2 3 4

22. My tinnitus has made me feel hopeless about the future. 0 1 2 3 4

23. My tinnitus has interfered with my sleep. 0 1 2 3 4

24. My tinnitus has led me to think about suicide. 0 1 2 3 4

25. My tinnitus has made me feel panicky. 0 1 2 3 4

26. My tinnitus has made me feel tormented. 0 1 2 3 4

Developed by Wilson et al, 1991

Tinnitus Cognitions Questionnaire

In this questionnaire, we would like to know what kinds of thoughts come into your head when you notice your tinnitus. Some of the thoughts you have might be rather negative and other might be more positive. You might not necessarily think all the thoughts listed below, but you may recognize some that apply to you. Please indicate how often you have been aware of thinking a particular thought on occasions when you have noticed the tinnitus.

0 = Never
1 = Rarely
2 = Occasionally
3 = Frequently
4 = Very Frequently

The first ones are the more *negative* thoughts that you might have:

1. I think, "If only the noise would go away." 0 1 2 3 4
2. I think, "Why me? Why do I have to suffer this horrible noise?" 0 1 2 3 4
3. I think, "What did I do to deserve this?" 0 1 2 3 4
4. I think, "The noise makes my life unbearable." 0 1 2 3 4
5. I think, "Nobody understands how bad the noise is." 0 1 2 3 4
6. I think, "If only I could get some peace and quiet." 0 1 2 3 4
7. I think, "I can't enjoy what I'm doing because of the noise." 0 1 2 3 4
8. I think, "How can I go on putting up with this noise." 0 1 2 3 4
9. I think, "The noise will drive me crazy." 0 1 2 3 4
10. I think, "Why can't anyone help me?" 0 1 2 3 4
11. I think, "My tinnitus is never going to get better." 0 1 2 3 4
12. I think, "The noise will overwhelm me." 0 1 2 3 4
13. I think, "With this noise, life is not worth living." 0 1 2 3 4

Now, here are the more *positive* thoughts that you might have:

14. I think, "No matter how unpleasant the noise gets, I can cope." 0 1 2 3 4
15. I think, "The noise might be unpleasant, but it won't drive me crazy." 0 1 2 3 4
16. I think, "I'll be able to enjoy things more if I keep my attention

off the noise."	0 1 2 3 4
17. I think, "I'm not the only person with tinnitus."	0 1 2 3 4
18. I think, "There are things in life worse than tinnitus."	0 1 2 3 4
19. I think, "The noise will eventually get less annoying if I try to distract myself from it."	0 1 2 3 4
20. I think, "I have coped with the noise before, so I can cope again this time."	0 1 2 3 4
21. I say to myself, "It will help if I try to think of something pleasant."	0 1 2 3 4
22. I tell myself, "I can learn to live with it."	0 1 2 3 4
23. I think, "The noise might be there, but I can still enjoy things."	0 1 2 3 4
24. I tell myself, "Think of something else other than the the noise."	0 1 2 3 4
25. I tell myself, "I won't think about the noise."	0 1 2 3 4
26. I think, "The noise is a nuisance, but I just won't let it bother me."	0 1 2 3 4

BECK DEPRESSION INVENTORY

Circle the number next to the answer that best reflects how you have been feeling recently. If more than one answer applies, circle the higher number. If in doubt, make your best guess. Do not leave any questions unanswered. Regardless of the outcome, this can be your first step toward emotional improvement.

1. 0 – I do not feel sad.
   1 – I feel sad.
   2 – I am sad all the time and I cannot snap out of it.
   3 – I am so sad or unhappy that I cannot stand it.

2. 0 – I am not particularly discouraged about the future.
   1 – I feel discouraged about the future.
   2 – I feel I have nothing to look forward to.
   3 – I feel that the future is hopeless and that things cannot improve.

3. 0 – I do not feel like a failure.
   1 – I feel I have failed more than the average person.
   2 – As I look back on my life, all I can see is a lot of failures.
   3 – I feel I am a complete failure as a person.

4. 0 – I get as much satisfaction out of things as I used to .
   1 – I do not enjoy things the way I used to.
   2 – I do not get real satisfaction out of anything anymore.
   3 – I am dissatisfied or bored with everything.

5. 0 – I do not feel I am being punished.
   1 – I feel I may be punished.
   2 – I expect to be punished.
   3 – I feel I am being punished.

6. 0 – I do not feel particularly guilty.
   1 – I feel guilty a good part of the time.
   2 – I feel quite guilty most of the time.
   3 – I feel guilty all of the time.

7. 0 – I do not feel disappointed in myself.
   1 – I am disappointed in myself.
   2 – I am disgusted with myself.
   3 – I hate myself.

8. 0 – I do not feel I am any worse than anybody else.
   1 – I am critical of myself for my weaknesses or mistakes.
   2 – I blame myself all the time for my faults.
   3 – I blame myself for everything bad that happens.

9. 0 – I do not have any thoughts of killing myself.
   1 – I have thoughts of killing myself, but I would not carry them out.
   2 – I would like to kill myself.
   3 – I would kill myself if I had the chance.

10. 0 – I do not cry any more than usual.
    1 – I cry more than I used to.
    2 – I cry all the time now.
    3 – I used to be able to cry, but now I cannot cry even though I want to.

11. 0 – I am no more irritated by things than I ever am.
    1 – I am slightly more irritated now than usual.
    2 – I am quite annoyed or irritated a good deal of the time.
    3 – I feel irritated all the time now.

12. 0 – I have not lost interest in other people.
    1 – I am less interested in other people than I used to be.
    2 – I have lost most of my interest in other people.
    3 – I have lost all of my interest in other people.

13. 0 – I make decisions as well as I ever could.
    1 – I put off making decisions more than I used to.
    2 – I have greater difficulty in making decisions than before.
    3 – I cannot make decisions at all anymore.

14. 0 – I do not feel that I look any worse than I used to.
    1 – I am worried that I am looking old or unattractive.
    2 – I feel that there are permanent changes in my appearance that make me look unattractive.
    3 – I believe that I look ugly.

15. 0 – I can work as well as before.
    1 – It takes an extra effort to get started at doing something.
    2 – I have to push myself very hard to do anything.
    3 – I cannot do any work at all.

16. 0 – I can sleep as well as before.
    1 – I do not sleep as well as I used to.
    2 – I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 – I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 – I do not get more tired than usual.
    1 – I get tired more easily than I used to.
    2 – I get tired from doing almost anything.
    3 – I am too tired to do anything.

BECK DEPRESSION IVENTORY
Continued

18. 0 – My appetite is no worse than usual.
    1 – My appetite is not as good as it used to be.
    2 – My appetite is much worse now.
    3 – I have no appetite at all anymore.

19. 0 – I have not lost much weight, if any, lately.
    1 – I have lost more than five pounds.
    2 – I have lost more than ten pounds.
    3 – I have lost more than fifteen pounds.

20. 0 – I am no more worried about my health than usual.
    1 – I am worried about my physical problems such as aches, pains, upset stomach, or constipation.
    2 – I am worried about my physical problems, and it is hard to think of much else.
    3 – I am so worried about my physical problems that I cannot think about anything else.

21. 0 – I have not noticed any recent change in my interest in sex.
    1 – I am less interested in sex than I used to be.
    2 – I am much less interested in sex now.
    3 – I have lost interest in sex completely.

Interpreting the Beck Depression Inventory. Now that you have completed the test, add up the score for each of the twenty-one questions and obtain the total. The highest possible score is 63 and the lowest possible score is zero. The higher the total score, the more severe your depression. In contrast, the lower score, the better you are feeling.

Although the BID test is not difficult or time-consuming to fill out and score, do not be deceived by its simplicity. You have just learned to use a highly sophisticated tool for diagnosing depression. Many research studies in the past decade have demonstrated that the BID test and similar moderating devices are highly accurate and reliable in detecting and measuring depression. In a recent study in a psychiatric emergency room, it was found that a self-rated depression inventory similar to the one you just filled out actually picked up the presence of depressive symptoms more frequently than formal interviewing by experienced clinicians who did not use the test. You can use the BID with confidence to diagnose yourself and monitor your progress.

Total Score	Level of Depression
1 - 10	These ups and downs are considered normal.
11 - 16	Mild mood disturbances.
17 - 20	Borderline clinical depression.
21 - 30	Moderate depression.
31 - 40	Severe depression.
41 and Over	Extreme depression.

Beck Anxiety Inventory (BAI)

Name: **Date:**

Below is a list of common symptoms of anxiety. Please indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column.

0 – NOT AT ALL
1 – MILDLY (It did not bother me much)
2 – MODERATELY (It was very unpleasant, but I could stand it)
3 – SEVERELY (I could barely stand it)

	NOT AT ALL	MILDLY	MODERATELY	SEVERELY
1. Numbness or tingling				
2. Feeling hot				
3. Wobbliness in legs				
4. Unable to relax				
5. Fear of the worst happening				
6. Dizzy or lightheaded				
7. Heart pounding or racing				
8. Unsteady				
9. Terrified				
10. Nervous				
11. Feelings of choking				
12. Hands trembling				
13. Shaky				
14. Fear of losing control				
15. Difficulty breathing				
16. Fear of dying				
17. Scared				
18. Indigestion or discomfort in abdomen				
19. Faint				
20. Face Flushed				
21. Sweating (not due to heat)				

Stress Symptom Checklist

Instructions: Check each item that describes a symptom you have experienced to any significant degree during the last month; then total the number items checked

Physical Symptoms

- ❑ Headaches (migraine or tension)
- ❑ Backaches
- ❑ Tight Muscles
- ❑ Neck and shoulder pain
- ❑ Jaw tension
- ❑ Muscle cramps, spasms
- ❑ Nervous stomach
- ❑ Other pain
- ❑ Nausea
- ❑ Insomnia (sleeping poorly)
- ❑ Fatigue, lack of energy
- ❑ Cold hands and/or feet
- ❑ Tightness or pressure in the head
- ❑ High blood pressure
- ❑ Diarrhea
- ❑ Skin condition (e.g. rash)
- ❑ Allergies
- ❑ Teeth grinding
- ❑ Digestive upsets (cramps, bloating)
- ❑ Heart beats rapidly or pounds even at rest
- ❑ Stomach pain or ulcer
- ❑ Constipation
- ❑ Hypoglycemia
- ❑ Appetite change
- ❑ Colds
- ❑ Profuse perspiration
- ❑ Overeating
- ❑ Weight change
- ❑ When nervous, use of alcohol, cigarettes, or recreational drugs

Psychological Symptoms

- ❑ Anxiety
- ❑ Depression
- ❑ Confusion or "spaciness"
- ❑ Irrational fears
- ❑ Compulsive behaviors
- ❑ Forgetfulness
- ❑ Feeling "overloaded" or "overwhelmed"
- ❑ Hyperactivity – feeling you can't slow down
- ❑ Mood swings
- ❑ Loneliness
- ❑ Problems with relationships
- ❑ Dissatisfied/unhappy at work
- ❑ Difficulty concentrating
- ❑ Frequent irritability
- ❑ Restlessness
- ❑ Frequent boredom
- ❑ Frequent worrying or obsessing
- ❑ Frequent guilt
- ❑ Temper flare-up
- ❑ Crying spells
- ❑ Nightmares
- ❑ Apathy
- ❑ Sexual problems

Evaluate your stress level as follows:

Number of items checked	Stress level
0 – 7	Low
8 – 14	Moderate
15 – 21	High
22+	Very high

Epworth Sleepiness Scale The Epworth Sleepiness Scale is widely used in the field of sleep medicine. It is used to determine the level of daytime sleepiness.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Print out this test, fill in your answers and see where you stand.

Situation	Chance of Dozing or Sleeping
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score (add the scores up) (This is your Epworth score)	____

Interpretation:
0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation.
16-24: You are excessively sleepy

For scores of 10 or more, you should evaluate whether you are obtaining adequate sleep. You may want to consider improving sleep hygiene and/or see a medical or sleep specialist