DAILY SLEEP INTERFERENCE SCALE:

☐ **NOT DONE**

Please complete the following upon awakening:

Today's Date:
(yyyy-mm-dd) |__|__|__|__|-|__|__|-|__|__|

Time of Day:
(24 hour clock) |__|__|:|__|__|

Select the number that best describes how much your pain has interfered with your sleep during the past 24 hours. (Check one number only)

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
Did not interfere with sleep										Completely interferes (Unable to sleep due to pain)