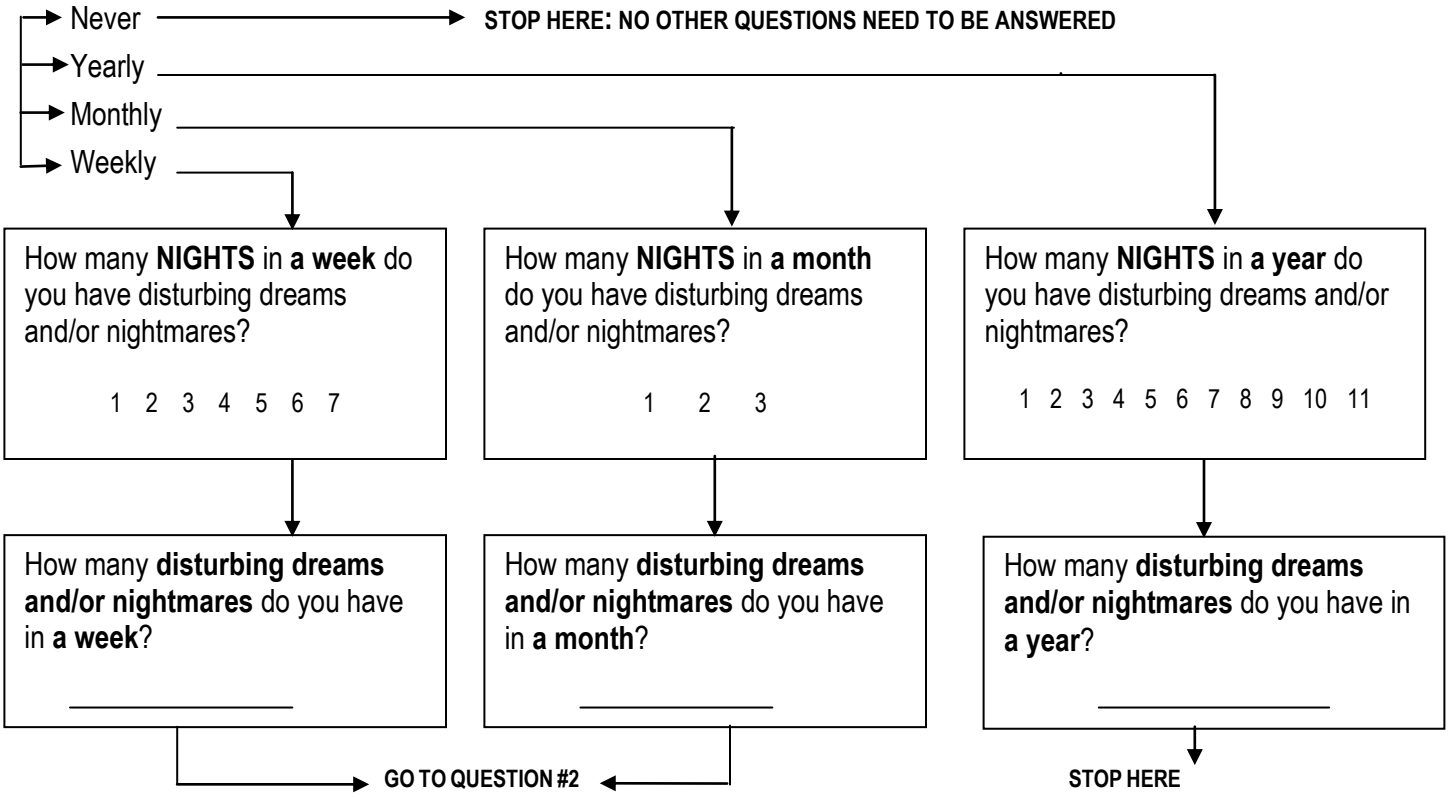
Participant ID: _____	Date: _____
Evaluator: _____	Appointment: _____

Disturbing Dream and Nightmare Severity Index-15

1. How often do you have disturbing dreams and/or nightmares: (Circle one, then follow the arrow)



2. Please estimate the **NUMBER** of months or years you have had disturbing dreams and/or nightmares:

   _____months _____years

3. On average, do your nightmares wake you up? (Circle answer)

   Never/Rarely Occasionally Sometimes Frequently Always

4. How would you rate the **SEVERITY** of your disturbing dreams and/or nightmare problem? (Circle answer)

No Problem	Minimal Problem	Mild Problem	Moderate Problem	Severe Problem	Very Severe Problem	Extremely Severe Problem

5. How would you rate the **INTENSITY** of your disturbing dreams and/or nightmares? (Circle answer)

Not Intense	Minimal Intensity	Mild Intensity	Moderate Intensity	Severe Intensity	Very Severe Intensity	Extremely Severe Intensity