

Self-Administered International Restless Legs Syndrome Study Group Severity Rating Scale (sIRLS[®])

Name: _____

Date of birth: _____

Today's date: _____

Carefully read each question and all answers:

What day was 7 days ago? _____ Think about your restless legs syndrome symptoms (RLS) during that day and **the next 7 days** up to today
not just the most recent or RLS worse days.

Report the **usual (not most or least severe)** effects of only RLS during the past 7 days regardless of any medications changes during that time.

Report **effects of only RLS** not other life or health problems in this past week.

In the past week...

1. Overall, how would you rate the RLS discomfort in your legs or arms?

Very severe Severe Moderate Mild None

In the past week...

2. Overall, how would you rate the need to move around because of your RLS symptoms?

Very severe Severe Moderate Mild None

In the past week...

3. Overall, how much relief of your RLS arm or leg discomfort do you get from moving around?

No relief Mild relief Moderate relief
Either complete or almost complete relief No RLS symptoms to be relieved

In the past week...

4. How severe was your sleep disturbance due to your RLS symptoms?

Very severe Severe Moderate Mild None

In the past week...

5. How severe was your tiredness or sleepiness during the day due to your RLS symptoms?

Very severe Severe Moderate Mild None

In the past week...

6. How severe was your RLS on a whole?

Very severe Severe Moderate Mild None

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In the past week...

7. How often did you get RLS symptoms?
- Very often (This means 6-7 days per week)
 - Often (This means 4-5 days per week)
 - Sometimes (This means 2-3 days per week)
 - Occasionally (This means 1 day per week)
 - Never

In the past week...

8. When you had RLS symptoms, how severe were they on average?
- Very severe (This means 8 hours or more per 24-hour day)
 - Severe (This means 3-8 hours per 24-hour day)
 - Moderate (This means 1-3 hours per 24-hour day)
 - Mild (This means less than 1 hour per 24-hour day)
 - None

In the past week...

9. Overall, how severe was the impact of your RLS symptoms on your ability to carry out your daily activities – for example, having a satisfactory family, home, social, school or work life?
- Very severe Severe Moderate Mild None

In the past week...

10. How severe was your mood disturbance due to your RLS symptoms – for example being angry, depressed, sad, anxious, or irritable?
- Very severe Severe Moderate Mild None

Supplemental question:

11. How do your usual RLS symptoms over a year compare to RLS symptoms for the last 7 days – which you reported above (circle the words):

- Usual symptoms are worse
- 1. Extremely worse
 - 2. Much worse
 - 3. Somewhat worse
 - 4. About the same
- Usual symptoms are better
- 5. Somewhat better
 - 6. Much better
 - 7. Extremely better

For office use only: Each item scored from 4 to 0. Total: _____		
Different levels of severity are roughly:		
0	=	No RLS
1-10	=	Mild
11-20	=	Moderate
21-30	=	Severe
31-40	=	Very severe

Comments: