Restless Legs Rating Scale

1. **In the past week, overall**, how would you rate the RLS discomfort in your legs or arms?
   - [] 0-None
   - [] 1- Mild
   - [] 2 – Moderate
   - [] 3 – Severe
   - [] 4 – Very Severe

2. **In the past week, overall**, how would you rate the need to move around because of your RLS symptoms?
   - [] 0-None
   - [] 1- Mild
   - [] 2 – Moderate
   - [] 3 – Severe
   - [] 4 – Very Severe

3. **In the past week, overall**, how much relief of your RLS arm or leg discomfort did you get from moving around?
   - [] No symptoms
   - [] Complete/nearly complete relief
   - [] Moderate relief
   - [] No relief

4. **In the past week**, how severe was your sleep disturbance due to your RLS symptoms?
   - [] 0-None
   - [] 1- Mild
   - [] 2 – Moderate
   - [] 3 – Severe
   - [] 4 – Very Severe

5. **In the past week**, how severe was your tiredness or sleepiness during the day due to your RLS symptoms?
   - [] 0-None
   - [] 1- Mild
   - [] 2 – Moderate
   - [] 3 – Severe
   - [] 4 – Very Severe

6. **In the past week**, how severe was your RLS as a whole?
   - [] 0-None
   - [] 1- Mild
   - [] 2 – Moderate
   - [] 3 – Severe
   - [] 4 – Very Severe

7. **In the past week**, how often did you get RLS symptoms?
   - [] 0-Never
   - [] 1- Occasional (1/week)
   - [] 2 – Sometimes (2-3/wk)
   - [] 3 – Often (4-5/wk)
   - [] 4 – Very often (6-7/wk)

8. **In the past week**, when you had RLS symptoms, how severe were they on average?
   - [] 0-None
   - [] 1- Mild
   - [] 2 – Moderate
   - [] 3 – Severe
   - [] 4 – Very Severe

9. **In the past week**, overall how severe was the impact of your RLS symptoms on your ability to carry out your daily affairs, for example carrying out a satisfactory family, home, social, school or work activity?
   - [] 0-None
   - [] 1- Mild
   - [] 2 – Moderate
   - [] 3 – Severe
   - [] 4 – Very Severe

10. **In the past week**, how severe was your mood disturbance due to your RLS symptoms – for example angry, depressed, sad, anxious or irritable?
    - [] 0-None
    - [] 1- Mild
    - [] 2 – Moderate
    - [] 3 – Severe
    - [] 4 – Very Severe

**Epworth Sleepiness Scale**

Please rate your chances of falling asleep or dozing in the following situations:

- **Situation**
- **Rating**
- Sitting and reading
  - [] never
  - [] slight
  - [] moderate
  - [] high
- Watching television
  - [] never
  - [] slight
  - [] moderate
  - [] high
- Sitting inactive in a public place
  - [] never
  - [] slight
  - [] moderate
  - [] high
- (movie or meeting)
- As a passenger in a car for an hour without a break
  - [] never
  - [] slight
  - [] moderate
  - [] high
- Lying down to rest in the afternoon
  - [] never
  - [] slight
  - [] moderate
  - [] high
- Sitting and talking to someone
  - [] never
  - [] slight
  - [] moderate
  - [] high
- Sitting quietly after lunch (without alcohol)
  - [] never
  - [] slight
  - [] moderate
  - [] high
- In a car, while stopped in traffic
  - [] never
  - [] slight
  - [] moderate
  - [] high