## Restless Legs Syndrome Rating Scale (IRLS)

(Investigator Version 2.1)

Ask the patient to rate his/her symptoms for the following ten questions. The patient and not the examiner should make the ratings, however the examiner should be available to clarify any misunderstandings the patient may have about the questions. The examiner should mark the patient's answers on the form.

In the past week...

(1) Overall, how would you rate the <u>RLS discomfort in your legs or arms</u>?

- $\Box$  Very severe
- $\Box$  Severe
- $\Box$  Moderate
- $\square$  Mild
- $\Box$  None

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

- $\Box$  Very severe
- $\Box$  Severe
- $\Box$  Moderate
- $\square$  Mild
- □ None

(3) <u>Overall</u>, how much <u>relief</u> from your RLS arm or leg discomfort did you get from moving around?

- $\Box$  No relief
- $\Box$  Mild relief
- □ Moderate relief
- □ Either complete or almost complete relief
- □ No RLS symptoms to be relieved

**INVESTIGATOR VERSION 2.1** 

In the past week...

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

- $\Box$  Very severe
- $\Box$  Severe
- $\Box$  Moderate
- $\square$  Mild
- □ None

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

- $\Box$  Very severe
- $\Box$  Severe
- $\Box$  Moderate
- $\square$  Mild
- $\Box$  None

## (6) How severe was your RLS on the whole?

- $\Box$  Very severe
- $\Box$  Severe
- $\Box$  Moderate
- $\square$  Mild
- □ None

(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 a week)
- $\Box$  Never

**INVESTIGATOR VERSION 2.1** 

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)
- $\Box$  None

(9) <u>Overall</u>, how severe was the impact of your RLS symptoms on your ability to carry out your <u>daily activities</u>, for example having a satisfactory family, home, social, school or work life?

- $\Box$  Very severe
- $\Box$  Severe
- $\Box$  Moderate
- $\square$  Mild
- $\Box$  None

(10) How severe was your <u>mood disturbance</u> due to your RLS symptoms - for example being angry, depressed, sad, anxious or irritable?

- $\Box$  Very severe
- $\Box$  Severe
- $\Box$  Moderate
- $\square$  Mild
- $\Box$  None