



## RESTLESS LEGS SYNDROME RATING SCALE

Have the patient rate his/her symptoms for the following ten questions.

The patient and not the examiner should make the ratings, but 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.

### QUESTION 1

In the past week...Overall, how would you rate the **RLS discomfort in your legs or arms?**

- ④ Very severe
- ③ Severe
- ② Moderate
- ① Mild
- ① None

### QUESTION 2

In the past week...Overall, how would you rate the **need to move** around because of your RLS symptoms?

- ④ Very severe
- ③ Severe
- ② Moderate
- ① Mild
- ① None

### QUESTION 3

In the past week...Overall, how much **relief** of your RLS arm or leg discomfort did you get from moving around?

- ④ No relief
- ③ Mild relief
- ② Moderate relief
- ① Either complete or almost complete relief
- ① No RLS symptoms to be relieved

### QUESTION 4

In the past week...How severe was your **sleep disturbance** due to your RLS symptoms?

- ④ Very severe
- ③ Severe
- ② Moderate
- ① Mild
- ① None

### QUESTION 5

In the past week...How severe was your **tiredness or sleepiness during the day** due to your RLS symptoms?

- ④ Very severe
- ③ Severe
- ② Moderate
- ① Mild
- ① None

### QUESTION 6

In the past week...How severe was your **RLS as a whole?**

- ④ Very severe
- ③ Severe
- ② Moderate
- ① Mild
- ① None

### QUESTION 7

In the past week...How **often** did you get RLS symptoms?

- ④ Very often (6 to 7 days in 1 week)
- ③ Often (4 to 5 days in 1 week)
- ② Sometimes (2 to 3 days in 1 week)
- ① Occasionally (1 day in 1 week)
- ① Never

### QUESTION 8

In the past week...When you had RLS symptoms, how severe were they on **average?**

- ④ Very severe (8 hours or more per 24 hour)
- ③ Severe (3 to 8 hours per 24 hour)
- ② Moderate (1 to 3 hours per 24 hour)
- ① Mild (less than 1 hour per 24 hour)
- ① None

### QUESTION 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.

- ④ Very severe
- ③ Severe
- ② Moderate
- ① Mild
- ① None

### QUESTION 10

In the past week...How severe was your **mood disturbance** due to your RLS symptoms? For example angry, depressed, sad, anxious or irritable.

- ④ Very severe
- ③ Severe
- ② Moderate
- ① Mild
- ① None