

Initial Sleep Clinic Intake

Wednesday, December 2, 2020

8:59 PM



Initial Sleep
Clinic Intake

Sleep Intake Form for Initial Visit

Full Name: M. Jones Social Security: 1234

Age: 23 Sex: M Rank: PFC MOS: 254

How long have you been suffering from sleep difficulties? 3 years

Do you have trouble falling asleep, staying asleep or both (please circle one)?

Approximately how much sleep on average do you get daily (add all sleep and naps): 6 hours

Approximately how much total time do you spend in bed (both asleep and awake time): 10 hours

How long does it take you (in minutes) to fall asleep after placing head on the pillow with intention to fall asleep?

150

What is your average bed time? 2300 Your desired length of sleep (hours): 7-8 hours

How many times (if any) do you have sleep disruptions during the night? NONE

What causes you to wake up in the middle of the night (if any): Circle all that apply: noise, need to use bathroom, no reason what-so-ever, racing heart, nightmares, sweating, other: N/A

What is your average wakeup time on workdays? 0530

What is your average wakeup time on the days when you don't have to work? 0800

How many naps (if any) do you take and their duration in hours? Once, 2 hours

Do you have racing thoughts or other worrying thoughts when you hit the pillow? Yes ☒ No ☐

Do you plan your next day affairs when you hit the pillow with intentions of falling asleep? Yes ☒ No ☐

Circle any of the following symptoms that apply to you: restless/creepy-crawly feelings in legs relieved with movement; acting-out in your sleep; walked-around in your sleep; snoring; snorted/choking in sleep; easily falling asleep during the day; Charlie horse with intense pain in leg muscles; suddenly passing out and losing control of your body

How much caffeine or other stimulants do you use (approx cups or drinks) daily? 3 cups

What time of the day do you exercise (if any)? 1900-2000

Prior sleep medications or other treatments? Circle any that apply: ambien, lunesta, trazodone, benadryl, atarax, melatonin, cough syrup, cognitive-behavioral therapy, other: melatonin, cough syrup

Current Medication (list any medications including supplements or over-the-counter medications):

NONE

Medication Allergies: NONE

How satisfied are you with the DURATION of your sleep in the past 2 weeks: please CIRCLE one

NOT AT ALL SATISFIED (1) | SOMEWHAT SATISFIED | MODERATELY SATISFIED | HIGHLY SATISFIED | EXTREMELY SATISFIED (5)

How satisfied are you with the DURATION of your sleep in the past 2 weeks: please CIRCLE one

NOT AT ALL SATISFIED (1) | SOMEWHAT SATISFIED | MODERATELY SATISFIED | HIGHLY SATISFIED | EXTREMELY SATISFIED (5)

How satisfied are you with the QUALITY of your sleep in the past 2 weeks: please CIRCLE one

NOT AT ALL SATISFIED (1) | SOMEWHAT SATISFIED | MODERATELY SATISFIED | HIGHLY SATISFIED | EXTREMELY SATISFIED (5)

Sleep Intake Form for Initial Visit

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate (by circling the number) to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, **circle a number that best reflects your personal experience**. Consider the whole scale, rather than only the extremes of the continuum.

1. I need 8 hours of sleep to feel refreshed and function well during the day.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
2. When I do not get proper amount of sleep on a given night, I need to catch up on the next day by napping or on the next night by sleeping longer.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
3. I am concerned that chronic insomnia may have serious consequences for my physical health.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
4. I am worried that I may lose control over my abilities to sleep.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
5. After a poor night's sleep, I know that it will interfere with my daily activities on the next day.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
6. In order to be alert and function well during the day, I am better off taking a sleeping pill rather than having a poor night's sleep.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
8. When I sleep poorly on one night, I know that it will disturb my sleep schedule for the whole week.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
9. Without an adequate night's sleep, I can hardly function the next day.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
10. I can't ever predict whether I will have a good or poor night's sleep.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
11. I have little ability to manage the negative consequences of disturbed sleep.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
12. When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
13. I believe that insomnia is essentially a result of a chemical imbalance.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
14. I feel that insomnia is ruining my ability to enjoy life and prevents me from doing what I want.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
15. Medication is probably the only solution to sleeplessness.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree
16. I avoid or cancel obligations (social, family, occupational) after a poor night's sleep.	Strongly Disagree	0	1	2	3	4	5	6	7	8	9	10	Strongly Agree

16. I avoid or cancel obligations (social, family, occupational) after a poor night's sleep.

Strongly
Disagree

Strongly Agree

Do you have any thoughts of killing yourself? Yes No

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

1. Feeling nervous, anxious or on edge

2. Not being able to stop or control worrying

0

1

2

3

0

1

2

3

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Not At All

Several
Days

More
Than Half
the Days

Nearly
Every
Day

1. Little interest or pleasure in doing things

0

1

2

3

2. Feeling down, depressed, or hopeless

0

1

2

3