

PATIENT – CLIENT INFORMATION

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____
(If different)

Phone: Primary _____ Secondary _____
(Best place to reach you)

Can we leave messages at either number? Yes or NO

If not, where would you like for us to leave a message? _____

Person responsible for your account _____ relationship _____

Relationship status: Single Married Partnered

Name of Spouse/Partner (parents/guardian for minor) _____

Children & Ages (siblings for minor) _____

Name of primary physician _____ Phone _____

In case of emergency notify _____ Relationship _____ Phone _____

Referred by _____

Please explain why you are seeking help at this time:

Please explain how your problems are affecting your work and relationships, plus your general functioning:

On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now _____

Please check any health problems you have or have had:

_____ lung	_____ high blood pressure	_____ arthritis
_____ liver	_____ diabetes	_____ other pain
_____ kidney	_____ seizures	_____ cancer
_____ stomach/intestinal	_____ head injury	

Page 2 – Patient/Client Information

Name _____ Date of Birth _____

Medicines you are allergic to:

Medicines you now take:

How much and what kind of exercise you get:

Height _____

Weight _____

SUBSTANCE USE

Average amount Past 2 months

Most ever used

Coffee

Cigarettes

Alcohol

Recreational Drugs

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

___ Physical health

___ In-law problems

___ Using drugs

___ Chronic Pain

___ Job or school performance

___ Panic Attacks

___ Low mood

___ Friendships

___ Phobias

___ Mood swings

___ Financial problems

___ Anxiety symptoms

___ Energy/motivation level

___ Obsessions (unwanted thoughts)

___ sweating

___ Memory

___ Nightmares

___ short of breath

___ Concentration

___ Thoughts of hurting someone

___ stomach upset

___ Sleep

___ Compulsions (unwanted actions)

___ dizziness

___ Sexual functioning

___ Flashbacks

___ choking

___ Suicidal thoughts

___ Paranoid thoughts

___ racing heart

___ Spirituality/religion

___ Domestic violence (verbal)

___ weakness

___ Marriage/relationship

___ Domestic violence (physical)

___ dry mouth

___ Family conflicts

___ Drinking alcohol

___ feeling trapped

___ panic

For the following, please circle YES or NO and give details:

Have you had counseling or psychotherapy in the past? YES - NO _____

Have you ever taken medication for your emotional or mental health? YES – NO _____

Have you ever been hospitalized for psychiatric problems? YES – NO _____

Have you ever been arrested? YES – NO _____

Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES – NO _____

Have you ever had any experiences that you would consider traumatic or abusive? YES - NO _____

Have you ever tried to kill yourself or hurt yourself in any way? YES – NO _____

Is there any danger these days that you might hurt yourself or someone else? YES – NO _____

Name _____ Date of Birth _____

Please describe your education:

Please describe the family you grew up in including your parents and names and ages of your siblings:

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:

Please describe your support system (family you are close to, friends you talk with, etc.):

What is your current job and how do you like it?

Please describe your religious affiliation and practice, if any:

FILL OUT THIS PAGE IF YOU HAVE SLEEP PROBLEMS

Name _____ Date of Birth _____

What is the main problem with your sleep? _____

Are you a shift worker? **YES** or **NO** If so, what hours do you work? _____

On average, how many hours of sleep do you get in 24 hours? _____

All at once or with naps? _____ Is this enough? **YES** **NO** Or too much? **YES** **NO**

INSOMNIA - POOR SLEEP QUALITY

Do you have problems getting to sleep or staying asleep? **YES** **NO**

If so, is your main problem getting to sleep, or waking up too much, or both? _____

Do you tend to sleep at the wrong time; that is, are you an extreme night owl or morning lark? **YES** **NO**

If so, what is your best window of time for sleeping? _____

Do you legs or arms itch, burn, tingle or just feel "fidgety" when you are trying to sleep? **YES** **NO**

EXCESSIVE SLEEP OR SLEEPINESS

Are you often too sleepy when you need to be awake? **YES** **NO**

On your usual schedule in recent weeks or months, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to answer according to how you think they might affect you. Choose the most appropriate number for each situation:
0 = would never doze **1 = slight chance of dozing** **2 = moderate chance** **3 = high chance of dozing**

Sitting & reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting in a public place, like a waiting room	0	1	2	3	The Epworth Sleepiness Scale (John, M.W. (1993) Chest 103:30-36)
Riding in a car for 1 hour	0	1	2	3	
Lying down to rest	0	1	2	3	
Sitting & talking	0	1	2	3	
Sitting after lunch without alcohol	0	1	2	3	
Driving a care while stopped in traffic	0	1	2	3	
Total Score	_____				

If your score is 10 or higher, a sleep disorders consultation is recommended.

Other situations in which you fall asleep when you don't mean to? _____

Do you snore? **YES** **NO** Loudly enough to disturb others? **YES** **NO** Stop Breathing? **YES** **NO**

SLEEP BEHAVIORS and OTHER PROBLEMS

Do your legs or arms twitch or jerk during sleep? **YES** **NO** Whole body? **YES** **NO**

If either, do these twitches or jerks seem to interfere with your sleep? **YES** **NO**

Do you sleepwalk or act out dreams? **YES** **NO**

Do you fall out of bed or have unusual movements during sleep? **YES** **NO**

Have you ever injured yourself or someone else while asleep? **YES** **NO**

Do you have nightmares? **YES** **NO**