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
___Chronic Pain
___ Low mood
___ Mood swings
___ Energy/motivation level
___ Memory
___ Concentration
___ Sleep
___ Sexual functioning
___Suicidal thoughts
___ Spirituality/religion
___ Marriage/relationship
___ Family conflicts

___ In-law problems
___ Job or school performance
___Friendships
___Financial problems
___ Obsessions (unwanted thoughts)
___ Nightmares
___ Thoughts of hurting someone
___ Compulsions (unwanted actions)
___ Flashbacks
___ Paranoid thoughts
___ Domestic violence (verbal)
___ Domestic violence (physical)
___ Drinking alcohol

___Using drugs
___Panic Attacks
___Phobias
___ Anxiety symptoms
___*sweating*
___ *short of breath*
___ *stomach upset*
___*dizziness*
___ *choking*
___ *racing heart*
___ *weakness*
___*dry mouth*
___ *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
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	_____

The Epworth Sleepiness Scale
(John, M.W. (1993) Chest 103:30-36)

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**