Buffalo Grove Sleep and Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

# INTAKE HISTORY: SLEEP/INSOMNIA

Provider Name: Mary Elizabeth Strain, PhD, Licensed Clinical Psychologist

## Patient Information:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Today's Date: | | | Date of Birth: | | | | | |
| Name: | | | Email Address: | | | | | |
| Address: | | | | | | | | |
| City: | | | State: | | | Zip: | | |
| Home Phone: | | | Work Phone: | | | Cell Phone: | | |
| May we call you at this number? | Yes | No | May we call you at this number? | Yes | No | May we call you at this number? | Yes | No |
| Ok to leave voice message? | Yes | No | Ok to leave voice message? | Yes | No | Ok to leave voice message? | Yes | No |

## Responsible Party Information *(If minor or dependent is involved)*

| | | |
|---|---|---|
| Name: | Date of Birth: | |
| Address: | Email Address: | |
| City | State: | Zip: |
| Home Phone: | Work Phone: | Cell Phone: |

## Insurance Information *(Please attach insurance card and photo ID for verification)*

| | | |
|---|---|---|
| Insured's Name: | | |
| Relationship to Patient: | | |
| Employer's Name: | | |
| Occupation: | | |
| Insurance Company Name: | | |
| Insurance ID Number: | Group/Plan Number: | |
| Insurance Company Phone: | | |

| FOR OFFICE USE ONLY | DX: | Session Fee: |
|---|---|---|
| | | |

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## Additional Information

| | |
|---|---|
| Emergency Contact: | Phone Number: |
| Relation to Patient: | |
| How were you referred to our practice? | |

## General Information

How can we help? Please briefly describe the primary reason you have come to our office:

Who is currently living in the household?

| | | |
|---|---|---|
| Name: | Age: | Relation: |
| Name: | Age: | Relation: |
| Name: | Age: | Relation: |
| Name: | Age: | Relation: |

| | | | | | | |
|---|---|---|---|---|---|---|
| Marital Status: | | | Occupation: | | | |
| Do you enjoy your work? | YES | NO | | | | |
| Are your parents living? | Mother | YES | NO | Father | YES | NO |

Educational level completed *(current students indicate current level)*

| GRADE SCHOOL | HIGH SCHOOL | COLLEGE | GRADUATE SCHOOL/OTHER |
|---|---|---|---|
| | | | |

If no, please specify cause of death and age:

| | | |
|---|---|---|
| Number of Brothers: | | Ages: |
| Number of Sisters: | | Ages: |
| Number of Children | | Ages: |

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## Medical Information

| | |
|---|---|
| Primary Care Doctor: | Office/Affiliation: |
| Psychiatrist (if applicable): | Office/Affiliation: |
| Other doctors/health care providers you see regularly: | |
| | |

| | | | |
|---|---|---|---|
| Have you ever been hospitalized for depression, anxiety, or another mental health condition? | YES | NO | |

## Current Medications

| Name of Medication: | Dosage/Frequency | For what condition? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Leisure

| |
|---|
| What do you enjoy doing when you aren't working? How often? (Daily, weekly, other). |
| |
| |

## Spiritual

| | | | | | |
|---|---|---|---|---|---|
| Are you religious/spiritual? | YES | NO | Do you meditate? | YES | NO |
| If yes, how do you express your religious/spiritual side? | | | | | |
| | | | | | |

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## *Social Support*

*Do you see yourself living in a supportive environment? (Circle appropriate number)*

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Not Well Supported* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *Very Well Supported* |

*At this time, what is the stress level in your life?*

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *No Stress* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *High Stress* |

## *Health Habits*

| | | | | |
|---|---|---|---|---|
| *Exercise* | ☐ *Sedentary (No exercise)* | | | |
| | ☐ *Mild exercise (i.e., climb stairs, walk 3 blocks, golf)* | | | |
| | ☐ *Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)* | | | |
| | ☐ *Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)* | | | |
| *Diet* | *Are you dieting?* | | ☐ *Yes* | ☐ *No* |
| | *If yes, are you on a physician prescribed medical diet?* | | ☐ *Yes* | ☐ *No* |
| *Caffeine* | ☐ *None* | ☐ *Coffee* | ☐ *Tea* | ☐ *Cola* |
| | *# of cups/cans per day?* | | | |
| *Alcohol* | *Do you drink alcohol?* | | ☐ *Yes* | ☐ *No* |
| | *If yes, what kind?* | | | |
| | *How many drinks per week?* | | | |
| | *Are you concerned about the amount you drink?* | | ☐ *Yes* | ☐ *No* |
| *Tobacco* | *Do you use tobacco?* | | ☐ *Yes* | ☐ *No* |
| | ☐ *# of years* | ☐ *Or year quit* | | |
| | | | ☐ *Yes* | ☐ *No* |

**Emotional/Physical Symptoms:** Have you experienced: (please check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Lack of Motivation | ☐ | Hyperactivity | ☐ | Irritability |
| ☐ | Worthlessnesss | ☐ | Chronic Worry | ☐ | Sleep Disturbance |
| ☐ | Depressed Mood | ☐ | Grief | ☐ | Hopelessness |
| ☐ | Anxiety | ☐ | Panic Attacks | ☐ | Increase/Decrease in Eating |
| ☐ | Obsessions/Compulsions | ☐ | Decrease in Social Relationships | ☐ | Attention/Concentration Problems |
| ☐ | Decrease in Family Relations | ☐ | Racing Thoughts | ☐ | Suicidal Thoughts |
| ☐ | Substance Use (Past/Present) | ☐ | Other: | | |

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# Sleep Evaluation Questionnaire

**Primary Sleep Problem (check all that apply):**

| | | | |
|---|---|---|---|
| □ | Difficulty falling asleep | □ | Early awakening |
| □ | Difficulty staying asleep | □ | Not feeling rested in the morning |
| □ | Daytime Sleepiness | □ | Behaviors during sleep |
| □ | Other: | | |

Please describe your sleep problem(s):

How long have you had a sleep problem?

How many nights a week do you have a sleep problem?

Have you had a sleep study? □No □Yes When? Where?

Please list any other treatment for your sleep problem (e.g., prescription medication, melatonin).

Current:

Past:

If discontinued, why?

| | | |
|---|---|---|
| Do you use a CPAP or BPAP? | □No □Yes | Problems with CPAP: |

**Daytime Sleepiness**

How likely are you to *doze off* or *fall asleep* in the following situations, in contrast to feeling tired? This refers to your usual way of life in recent times. Even if you have not done some these things recently, try to work out how they would have affected you. Please select one response per line.

| CHANCE OF DOZING OFF | | | | |
|---|---|---|---|---|
| | Never | Slight | Moderate | High |
| Sitting and reading | | | | |
| Watching TV | | | | |
| Sitting, inactive in a public place (e.g., theater or a meeting) | | | | |
| As a passenger in a car for an hour without a break. | | | | |
| Lying down to rest in the afternoon when circumstances permit | | | | |
| Sitting and talking to someone | | | | |
| Sitting quietly after lunch without alcohol | | | | |
| In a car, while stopped for a few minutes in traffic | | | | |

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| **The Sleep Disorders Symptom Checklist (SDS-CL)**<br><br>(Perlis, Jungquist, Smith, & Posner, 2005) | **Never** | **Seldom** | **Sometimes** | **Often** | **Always** |
|---|---|---|---|---|---|
| It takes me 30 or more minutes to fall asleep | | | | | |
| I wake up for 30 or more minutes during the night | | | | | |
| I wake up 30 or more minutes prior to my alarm | | | | | |
| | | | | | |
| I prefer to go to bed early (before 10:00 p.m.) and wake up early (before 5:30 a.m.) | | | | | |
| I prefer to go to bed late (after 1:00 a.m.) and wake up late (after 9:00 a.m.) | | | | | |
| | | | | | |
| I am prone to falling asleep at inappropriate times and places. | | | | | |
| | | | | | |
| I wake up with headaches in the morning | | | | | |
| I wake up with a dry mouth in the morning (“cotton mouth”) | | | | | |
| I snore | | | | | |
| My snoring is so loud, that my bed partner complains. | | | | | |
| I wake up choking or gasping for air. | | | | | |
| My bed partner has noticed that I seem to stop breathing. | | | | | |
| | | | | | |
| I get uncomfortable sensations in my legs. | | | | | |
| In the evenings my legs feel “restless” | | | | | |
| I often feel that I have to get up and walk around | | | | | |
| I have been told that I am a restless sleeper. | | | | | |
| My bed partner complains that I move around a lot at night | | | | | |
| | | | | | |
| When excited (e.g., anger or humored) I feel physically weak | | | | | |
| When I am falling asleep, I experience scary dream like images. | | | | | |
| When I am first awakening, I experience scary dream like images. | | | | | |
| When I am first awakening, I feel like I can’t move | | | | | |
| | | | | | |
| I have nightmares, particularly in the first ½ of the night. | | | | | |
| I have nightmares, particularly in the latter ½ of the night. | | | | | |
| For no reason, I awaken suddenly, startled, and feeling afraid. | | | | | |