Jeffrey Young, PHD, CBSM (818-905-7121)
Patient Name_____ Date filled out _____

Medical & Psychiatric Conditions (Current and Past)

Begin by listing any current medical and/or psychiatric conditions you currently have and include when you were first diagnosed.
Then, list any past medical and/or psychiatric conditions and when it began and when it ended. Feel free to identify any condition that you think might have contributed to any problem you are having now.

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List of ***Current*** Prescription Medications, Herbals, Over-the Counter.

List here all current Medications even if you use it just as needed or very rarely. Use as much space or lines as you need for a given medication and provide information in the following order and skip a line between medications for clarity. Use the following format and include as much information as you can. Feel free to identify any medication that you think might be contributing to any problem you are having now.

Medication Name, Dosage, Time(s) of Dose, Disorder Treated, Start Date, Side Effects/Problems, Effectiveness, Prescribed by and Specialty
Effectiveness: **A**) You can rate effectiveness numerically from 1 to 5 with 5 being highest, **B**) indicate if the effectiveness has varied over time.

Example: Xanax, .5mg, .5 in am .5 in pm, anxiety, 4/2015, .5 unless having a rare panic attack then only effective if I take a double dose of 1.0mg- tends not to be as effective as when first prescribed, Dr. Alan Jones, PCP Internal Medicine.

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Current Meds Continued

Surgical Procedures and Dates

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Past Relevant Medications

List of *Past Relevant* Prescription Medications, Herbals, Over-the Counter

Relevant here means that you do not have to list every medication. However, it is helpful to know if you have been on certain medications for depression, anxiety, or sleep and why those were discontinued. Feel free to identify any medication that you think might have contributed to any problem you are having now or any that were particularly helpful at that time.

Medication Name, Dosage, Time(s) of Dose, Disorder Treated, Start Date, Side Effects/Problems, Effectiveness, Prescribed by and Specialty

Effectiveness: **A**) You can rate it numerically from 1 to 5 with 5 being highest, **B**) indicate if effectiveness has varied over time.

Add in the **Stop Date and Reason for Stopping** and if a **replacement** medication was prescribed.

Example: Xanax, .5mg, .5 in am .5 in pm, anxiety, 4/2015, 5 unless having a rare panic attack then only effective if I take a double dose of 1.0mg- tends not to be as effective as when first prescribed, **Stopped 6/2016** due to **reduced effectiveness** – started **Prozac** to replace, Dr. Alan Jones, PCP Internal Medicine.

Allergies: Medication, Food, and Environment Induced

Let me know if these are managed by avoiding the trigger or by medication

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Patient Name_____ **Date filled out** _____

THE EPWORTH SLEEPINESS SCALE

Name: _____
Today's Date: _____ Your Age (years): _____
Your sex (male = M; female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in the past week. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a 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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

FLINDERS FATIGUE SCALE

We are interested in the extent that you have felt **fatigued** (tired, weary, exhausted) over the last **two weeks**. We **do not** mean feelings of **sleepiness** (the likelihood of falling asleep). Please circle the appropriate response in accordance with your average feelings over this two-week period.

1. Was fatigue a problem for you?
☐ Not at all ☐ Moderately ☐ Extremely
2. Did fatigue cause problems with your everyday functioning (e.g., work,social, family)?
☐ Not at all ☐ Moderately ☐ Extremely
3. Did fatigue cause you distress?
☐ Not at all ☐ Moderately ☐ Extremely
4. How often did you suffer from fatigue?
☐ 0 days/week ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5-6 days/week ☐ 7 days/week
5. At what time(s) of the day did you typically experience fatigue? (Please tick box(es))
☐ Early morning ☐ Mid morning ☐ Mid afternoon ☐ Late afternoon
☐ Early evening ☐ Midday ☐ Late evening
6. How severe was the fatigue you experienced?
☐ Not at all ☐ Moderate ☐ Extreme
7. How much was your fatigue caused by poor sleep?
☐ Not at all ☐ Moderately ☐ Entirely

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Patient Name_____ Date filled out _____

Patient Name _____ **Date** _____

PHQ-9

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

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Name_____ Date_____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score _____