Integrated Sleep & Wellness

Adult Sleep Evaluation Packet

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Name: **Date:**

Referring Provider:

Briefly describe the problem (s) with sleep you are having or the reason you are seeking treatment?

_____

_____

Please check if you have any of the problems below:

____ Difficulty initiating sleep ____ Difficulty maintaining sleep

____ Early morning awakening ____ Difficulties waking at intended time

When did you first become aware that there was a problem with your sleep? Please identify any contributing factors to the onset of your sleep problems (i.e., health problems, traumatic event, loss of a loved one).

_____

_____

What do you think are contributing factors to your sleep problems today?

_____

_____

Psychosocial History

Did you have any sleep problems or mental health problems as a child/adolescent? If so, please explain:

_____

_____

_____

Family history of insomnia and other sleep disorders (i.e., obstructive sleep apnea)? _____

_____

Family history of mental health problems (i.e., depression, schizophrenia, anxiety, etc.)?

_____

_____

Are you experiencing any family and/or work related conflicts or problems at this time? Yes No

If yes, please explain: _____

How many times have you been married?_____

What is your current status? Please circle –married single partner separated divorced widowed

How many children do you have? _____Any problems with parenting? If so please explain:

_____

How is your relationship with your children? Circle – Good Fair Poor

Do you have friends or family to which you socialize with? Circle – Yes No

Substance Use and Other Addictive Behaviors

Do you currently drink alcohol? Circle - Yes No

How often? (Once a week, once a month, once a year) _____

If so, how many drinks do you have per occasion? (i.e., 1-2, 3-4, or 5+ drinks) _____

Do you currently use illicit (nonprescription) drugs including marijuana? Circle – Yes No

If so, which type of drug (i.e., marijuana, cocaine) and how often (once a week, once a month)?

_____

Are you currently or have you ever used alcohol and/or illicit drug (i.e., marijuana) to help you sleep? If so, please indicate which one (s)? _____

In the past, have you ever been in treatment and/or had legal problems (i.e., DUI) related to your alcohol or drug use? Please give your best estimate of dates and names of treatment facilities:

_____

_____

Do you currently smoke cigarettes (circle)? Yes No How many cigarettes per day?_____

Please indicate if you smoked cigarettes in the past and your quit date? _____

Do you gamble? Circle –Yes No If so how often? _____

Have you been in treatment before in the past for gambling? _____

How many caffeinated beverages (i.e., coffee, soda, energy drinks) do you drink per day? Please indicate which type? _____

Medical History

Please circle if you have had any of the medical problems listed below. Please list when you were diagnosed and treatment:

Allergies _____

Asthma _____

Arthritis _____

Cancer _____

COPD_____

Coronary Artery Disease _____

CVA or Stroke _____

Diabetes _____

Digestive Problems _____

Epilepsy _____

Head Injury/TBI _____

High Blood Pressure _____

Hepatitis _____

Sleep Apnea _____

Seizure Disorder _____

Tinnitus (Ringing in ears) _____

Other: _____

Pain Condition*** _____

****Please rate the severity of your pain currently, on a scale from 0-10, with 10 indicating the most severe pain you can imagine _____.

Please list past surgeries (i.e., gastric bypass, heart surgery, etc.): _____

_____

_____

What sleep medications have you taken in the past (both prescribed and over counter)?

Name	Dose	Manner used (@ BT, Middle of night; PRN)	How long?	Helpful?

What current sleep medications are you currently taking (both prescribed and over counter)?

Name	Dose	Manner used (@ BT, Middle of night; PRN)	How long?	Helpful?

Please list other prescription medications you are currently taking (use back of sheet if needed):

_____

_____

_____

Psychiatric History

Have you ever been diagnosed with or treated for a psychiatric/mental health problem (i.e., depression, anxiety, Bipolar, PTSD) in the past? Please list: _____

_____

_____

Are you currently being treated for a psychiatric disorder? Yes No If yes, who is your current provider(s) and what is the focus of treatment (Psychotherapy vs. medication)? _____

_____

Have you ever been hospitalized for psychiatric/emotional problems? If so, when and where?

_____

_____

Are you currently prescribed psychiatric medication (i.e., antidepressants, mood stabilizers, etc.)?

_____

Do you have a history of suicide attempts? If so, approximate dates_____

_____

Are you having thoughts about committing suicide currently? Circle Yes No

Are you having thoughts about homicide or killing others? Circle Yes No

Sleep habits (Please focus on a recent typical week):

What time do you "try" to go to sleep meaning lights out? _____

On average, how long does it usually take you to fall asleep? _____

Do you have any pre- bedtime activities (i.e., reading, taking a bath, listening to music)? Is this done in your bed? _____

_____

What happens when you cannot get to sleep (thoughts/behaviors)? _____

_____

How many awakenings do you have in an average night?_____

What happens when awake in the middle of the night (thoughts/behaviors)? _____

_____

What time do you typically wake up?_____

What time do you get out of bed to start your day? Is this the same on weeknight versus weekend?

_____

How many hours do you estimate that you actually sleep? _____

Do you take naps? For how long?_____

If you were given the opportunity to nap could you? _____

How much sleep do you feel you need each night to feel rested and able to function? _____

Is there is any unusual aspects of your sleep environment (i.e., bed partner, childcare, pets, comfort, sound, lights, safety, temperature) that impacts your sleep? _____

_____

Daytime effects:

Do you feel your sleeping problem impacts any of the factors below and how so?

Energy/fatigue: _____

Memory/ Ability to Concentration_____

Mood (i.e., feel more irritable, anxious, depressed): _____

Daytime activity levels: _____

Ability to work: _____

Other please describe: _____

Sleep Behaviors/Symptoms: Please Circle Yes or No

Has you ever been told by anybody that you snore loudly?	Yes	No
Has your bed partner told you that you quit breathing at night?	Yes	No
Do you have morning headaches?	Yes	No
Are you still sleepy even when you sleep 8 hours or increase your sleep time?	Yes	No
Have you ever had times to which she felt "frozen" or paralyzed while trying to fall asleep and/or waking up?	Yes	No
Have you ever had what felt like a dream and/or visual hallucination when falling to sleep?	Yes	No
Do you have episodes when you feel you cannot stay awake during the day?	Yes	No
Have you ever had episodes of sudden muscle loss or weakness (i.e., legs going limp) during times when you felt intense emotions (i.e., anger, laughing)?	Yes	No
Do you sleep walk?	Yes	No

Do you have nightmares frequently?	Yes	No
Have you been told by a bed partner that you kick, punch and/or can be violent in your sleep?	Yes	No
If yes to above, do you remember these episodes?	Yes	No
Do you wake up screaming during the night?	Yes	No
Do you eat during the night?	Yes	No
Do you grind your teeth while sleeping?	Yes	No
Do you have a hard time falling asleep due to discomfort in your legs?	Yes	No
If yes to above, do you have to get up or move your legs for some relief?	Yes	No
Do you ever tingling and/or creepy crawling sensations in your legs?	Yes	No
Do your legs jerk at night when trying to fall asleep?	Yes	No

Please list any goals you have for treatment:

_____

_____

_____

_____

_____