

THE CENTER FOR SLEEP MEDICINE

# Insomnia Treatment and Evaluation Program

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Evaluation Orientation

You or your doctor indicated that your primary sleep difficulty is insomnia. Our treatment approach for insomnia reflects the National Institutes of Health treatment consensus for insomnia and emphasizes initial non-medication, treatment approaches.

Your initial appointment is scheduled with one of our insomnia specialists (Ph.D.), certified in behavioral sleep medicine. The specialist will conduct a thorough evaluation of factors that contribute to your sleep difficulty. As part of the evaluation, you will be assessed for other sleep disorders that may occur with insomnia. Following the evaluation, you should have an improved understanding of your sleep difficulties, as well as an integrated treatment plan. If you are already on medications or would like medications, options that involve medication may be included as part of the treatment. If your physician also ordered a sleep study, the specialist will discuss the study with you should it still be necessary after your consultation.

Attached, please find a questionnaire about your sleep. Please complete this questionnaire and bring it with you to your evaluation. In addition, a sleep log is provided. Please maintain the sleep log between the day you received this packet and the date of your scheduled visit. Bring this packet with you to your next visit.

We make every effort to see our patients at their scheduled appointment time. If for any reason you need to cancel your appointment, please do so 24 hours before the appointment time. "No shows" or late cancellations will be charged for the appointment. In such a case, this fee is not covered by insurance or Medicare.

If you have any questions or concerns about the materials, or to contact Center scheduling staff, please call 708-364-0261 x1.

## Sleep Problem Description

Please help us understand the nature of your insomnia and sleep impairment. Complete each item below.

- |  | Not at<br>all            | A<br>little              | Some                     | Much                     | Very<br>much             |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. To what extent are you experiencing difficulties with:                              |                          |                          |                          |                          |                          |
| a. Falling asleep  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Staying asleep  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Waking too early in the morning   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Sleepiness or staying awake during the day  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Unwanted behaviors during sleep   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Nightmares or vivid dreams  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How long does it usually take you to fall asleep?                                   | _____ (Min or Hrs)       |                          |                          |                          |                          |
| 3. How many times do you wake up during the night?                                     | _____                    |                          |                          |                          |                          |
| 4. How long are you usually awake after waking up at night?                            | _____ (Min or Hrs)       |                          |                          |                          |                          |
| 5. How often during a week do you nap?   | _____                    |                          |                          |                          |                          |
| 6. On how many nights during an average week do you experience sleep difficulties?     | _____                    |                          |                          |                          |                          |
| 7. How long have you experienced sleep difficulties? (indicate weeks, months or years) | _____                    |                          |                          |                          |                          |

## Origin and History

- |   | Not at all               | A little                 | Some                     | Much                     | Very much                |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Rate the extent to which you feel the following factors may contribute to your sleep difficulties:                           |                          |                          |                          |                          |                          |
| a. Racing thoughts at night (e.g. mental activity)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Physical discomfort (e.g. muscle tension and pain)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Poor sleep habits  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Mood (Depression or Anxiety)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Natural aging (including menopause)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A variable sleep schedule  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Personal stressors (e.g. relationship or family domain)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Work stressors (e.g. work demands, job security)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Weight gain or loss  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Medication(s)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Medical condition(s)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Travel schedule  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Was there any stressful event or life situation that seems to have occurred around the time your sleep difficulties emerged? |                          |                          | Yes                      | No                       |                          |
|   |                          |                          | <input type="checkbox"/> | <input type="checkbox"/> |                          |

If yes, please briefly describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Impairment

- |   | Not at all               | A little                 | Some                     | Much                     | Very much                |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. How impaired are you by your sleep difficulties?                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How much do your difficulties affect your:   |                          |                          |                          |                          |                          |
| a. Ability to function at work  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Family and social relationships  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Mood   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Memory, attention and concentration  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Medical and health conditions  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. How noticeable to others is your sleep problem?                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. How concerned are you about your sleep difficulties?                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Please tell us about any other way in which you feel your sleep problem affects you: |                          |                          |                          |                          |                          |

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## Beliefs and Attitudes About Your Sleep

Beliefs and attitudes about sleep both shape, and are shaped by, sleep difficulties. Below are several statements about sleep related beliefs and attitudes. Please indicate to what extent you personally *agree* or *disagree* with each statement. There are no correct or incorrect answers.

|     |   | Strongly<br>Disagree     | Disagree                 | Neutral                  | Agree                    | Strongly<br>Agree        |
|-----|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1.  | I need 8 hours of sleep to feel refreshed and function well during the day.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.  | When I don't get the amount of sleep I need, I have to catch up the next day by napping or on the next night by sleeping longer.                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.  | Because I am getting older, I need less sleep.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.  | I am worried that if I go for one or two nights without sleep, I may have a nervous breakdown.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.  | I am concerned that chronic insomnia may have serious consequences for my physical health.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.  | By spending more time in bed, I usually get more sleep and feel better the next day.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.  | When I have trouble getting to sleep I believe I should stay in bed and try harder.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.  | I am worried that I may lose control over my abilities to sleep.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.  | Because I am getting older, I should go to bed earlier in the evening.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | After a poor night's sleep, I know that it will interfere with my daily activities on the next day.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | In order to be alert and function well during the day, I am better off taking a sleeping pill rather than having a poor night's sleep.            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | When I feel irritable, depressed or anxious during the day, it is because I did not sleep well the night before.                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | Because my bed partner falls asleep as soon as his or her head hits the pillow and stays asleep through the night, I should be able to do so too. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | I feel that insomnia is basically the result of aging, and there isn't much that can be done about this problem.                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | I am sometimes afraid of dying in my sleep.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | When I have a good night's sleep, I know that I will have to pay for it on the following night.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | When I sleep poorly on one night, I know it will disturb my sleep schedule for the whole week.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## Beliefs and Attitudes About Your Sleep (Continued)

|   | Strongly Disagree        | Disagree                 | Neutral                  | Agree                    | Strongly Agree           |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 18. Without an adequate night's sleep, I can hardly function the next day.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. I can't ever predict whether I'll have a good or poor night's sleep.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. I have little ability to manage the negative consequences of disturbed sleep.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. I get overwhelmed by my thoughts at night and often feel I have no control over my racing mind.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. I feel I can still lead a satisfactory life despite sleep difficulties  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. I believe insomnia is essentially the result of a chemical imbalance.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. I feel insomnia is ruining my ability to enjoy life and prevents me from doing what I want.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. I avoid or cancel obligations (social, family, occupational) after a poor night's sleep.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. A "nightcap" before bedtime is a good solution to sleep problems.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Medication is probably the only solution to sleeplessness.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. My sleep is getting worse all the time, and I don't believe anyone can help.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. It usually shows in my physical appearance when I haven't slept well.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Other: (Please describe and rate): _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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## Prior Treatment and Treatment Perspective

Please help us understand what kinds of approaches you have tried in the past or are currently using to resolve your sleep problem:

|   | Past Use                 | Current Use              |
|---|--------------------------|--------------------------|
| 1. Alcohol  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Over-the-Counter sleep aids (e.g. Tylenol PM, Sominex, etc.)                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Prescription sleep aids:   |                          |                          |
| a. Lunesta (Eszopiclone)  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Ambien (Zolpidem)  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Ambien CR (Zolpidem Extended Release)  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Rozerem (Ramelteon)  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Sonata (Zaleplon)  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Benzodiazepines (e.g. Lorazepam, Xanax, Klonopin, etc.)                              | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Trazodone  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other prescription medications: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Melatonin  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Herbal Supplements/Tea (e.g. Ginkgo Biloba, Valerian Root)                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other controlled substances (e.g. Marijuana)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Literature (e.g. books, pamphlets)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Relaxation Exercises/Yoga/Meditation   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Cognitive Behavioral Treatment   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Psychotherapy   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. If your insomnia were successfully treated, in what ways would your life be better? |                          |                          |

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12. If there was a treatment we could use that would fix your sleep difficulty, but to get better it would mean that you'd get worse before you got better, how much worse would you be willing to get?

|                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10%                      | 20%                      | 30%                      | 40%                      | 50%                      | 60%                      | 70%                      | 80%                      | 90%                      | 100%                     |

13. To make a difference in your life, how much improvement would represent a real accomplishment?

|                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10%                      | 20%                      | 30%                      | 40%                      | 50%                      | 60%                      | 70%                      | 80%                      | 90%                      | 100%                     |

## Brief Patient Health Questionnaire™ (PHQ)

How we feel in terms of mood, stress and anxiety can both cause and contribute to sleep difficulties. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

|  | Not at<br>All            | Several<br>Days          | More than<br>Half the Days | Nearly<br>Everyday       |
|--|--------------------------|--------------------------|----------------------------|--------------------------|
| 1. Over the <i>last 2-weeks</i> , how often have you been bothered by any of the following problems?   |                          |                          |                            |                          |
| a. Little interest or pleasure in doing things   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| b. Feeling down, depressed or hopeless   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| c. Trouble falling or staying asleep, or sleeping too much   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| d. Feeling tired or having little energy   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| e. Poor appetite or overeating   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| g. Trouble concentrating on things, such as reading the newspaper or watching television   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| i. Thoughts that you would be better off dead, or of hurting yourself in some way  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
|  |                          |                          | Yes                        | No                       |
| 2. In the <i>last 4-weeks</i> , have you had an anxiety attack—suddenly feeling fear or panic? <i>(If you answered NO to question #2, go on to question #3)</i>  |                          |                          | <input type="checkbox"/>   | <input type="checkbox"/> |
| a. Has this ever happened before?  |                          |                          | <input type="checkbox"/>   | <input type="checkbox"/> |
| b. Do some of these attacks come <i>suddenly out of the blue</i> – that is, in situations where you don't expect to be nervous or uncomfortable?   |                          |                          | <input type="checkbox"/>   | <input type="checkbox"/> |
| c. Do these attacks bother you a lot or are you worried about having another attack?   |                          |                          | <input type="checkbox"/>   | <input type="checkbox"/> |
| d. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach? |                          |                          | <input type="checkbox"/>   | <input type="checkbox"/> |
| 3. If you checked off any problems on this PHQ 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?       |                          |                          |                            |                          |
| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |                          |
| Not Difficult at All   | Somewhat Difficult       | Very Difficult           | Extremely Difficult        |                          |

**PHQ (Continued)**

|   | Not Bothered             | Bothered a Little        | Bothered a Lot           |
|---|--------------------------|--------------------------|--------------------------|
| 4. In the last 4-weeks, how much have you been bothered by any of the following problems?   |                          |                          |                          |
| a. Worrying about your health   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your weight or how you look  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Little or no sexual desire or pleasure during sex  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulties with your husband/wife, partner/lover, or boyfriend/girlfriend  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The stress of taking care of children, parents, or other family members  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stress at work, outside of the home, or at school  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Financial problems or worries  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Having no one to turn to when you have a problem   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Something bad that happened recently   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Thinking or dreaming about something terrible that happened to you <i>in the past</i> – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. What is the most stressful thing in your life right now?   |                          |                          |                          |

**Medical Conditions and Medications**

Please describe any medical conditions you may have and any medications you are currently taking:

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Patient Name: \_\_\_\_\_

| <b>Insomnia Program Pre Evaluation Sleep Log</b>  |                              |                |                |                |                |                |                |                |
|---|------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| For the week prior to your appointment, please complete the following sleep log <b>each day</b> as accurately as you can.           |                              |                |                |                |                |                |                |                |
|   | <b>Sample</b>                | <b>Night 1</b> | <b>Night 2</b> | <b>Night 3</b> | <b>Night 4</b> | <b>Night 5</b> | <b>Night 6</b> | <b>Night 7</b> |
| Indicate date and day of the week:  | <b>10/5<br/>Monday</b>       |                |                |                |                |                |                |                |
| What time did you get into bed?   | <b>10:30 pm</b>              |                |                |                |                |                |                |                |
| What time did you get out of bed?   | <b>6:30 am</b>               |                |                |                |                |                |                |                |
| Approximately how many hours did you sleep last night?  | <b>6½ hrs</b>                |                |                |                |                |                |                |                |
| What was the quality of your sleep? (1-5)<br>1 = Very Poor; 2 = Poor; 3 = Fair; 4 = Good; 5 = Very Good                             | <b>2</b>                     |                |                |                |                |                |                |                |
| How did you feel when you got up? (1-5)<br>1 = Not Rested; 2 = Slightly Rested; 3 = Somewhat Rested;<br>4 = Rested; 5 = Well Rested | <b>3</b>                     |                |                |                |                |                |                |                |
| How long did it take you to fall asleep?  | <b>40 min</b>                |                |                |                |                |                |                |                |
| How many times did you awaken?  | <b>3</b>                     |                |                |                |                |                |                |                |
| Estimate how long (in minutes) you were awake during these awakenings?  | <b>50 min</b>                |                |                |                |                |                |                |                |
| List the time and duration of any naps you took during the day?   | <b>1:30 pm.<br/>(1 hour)</b> |                |                |                |                |                |                |                |
| List any over-the-counter or prescription sleep medication you took last night:   | <b>Sleep Aid<br/>10 mg</b>   |                |                |                |                |                |                |                |
| Rate your level of daytime stress (1-5):<br>1= Minimal; 2 = Mild; 3 = Moderate; 4 = High; 5 = Severe                                | <b>2</b>                     |                |                |                |                |                |                |                |
| Rate your level of nighttime pain (1-5):<br>1= Minimal; 2 = Mild; 3 = Moderate; 4 = High; 5 = Severe                                | <b>0</b>                     |                |                |                |                |                |                |                |
| Exercise: (note time/description)   | <b>20 min<br/>Treadmill</b>  |                |                |                |                |                |                |                |