The Center for Sleep Medicine

The Gold Standard in Sleep Care

Behavioral Sleep Medicine Program

Initial Evaluation Questionnaire

Important Instructions

1. **Please complete this packet and bring it with you to your first appointment.**

2. **If you need to cancel or reschedule your appointment, you *must* do so 24 hours before the appointment time (as stated in our practice policy). We usually dedicate an hour to your initial visit so it is important we know ahead of time if you will not be making your appointment. Cancellations in less than 24 business hours and "no shows" make it difficult for us to accommodate anyone else in this timeslot and lengthen the wait time for other patients.**

3. ***Starting the week before your scheduled appointment*, please maintain the sleep log on the next page to the best of your ability. If you obtain this packet less than a week before your appointment, please maintain the log starting the day you receive it.**

Introduction to Our Services

You have an appointment scheduled with a clinician (Ph.D/Psy.D) specializing in Behavioral Sleep Medicine (BSM). BSM is an area of sleep medicine offering research supported, non-medication treatments for a variety of sleep difficulties.

Your initial visit with a BSM Specialist will focus on evaluation of behavioral, psychological, and physiological factors contributing to your specific symptoms. Following the evaluation, we will develop a treatment plan tailored to your needs. We will begin our discussion of recommendations toward the end of the initial visit (as time permits) or at the second session. If we identify possible signs of a biologically-based sleep disorder warranting additional assessment, we will encourage you to consult with one of our sleep physicians or nurse practitioners regarding the medical concern.

Insomnia (frequent difficulty falling asleep or staying asleep) is the most common condition we address as BSM Specialists. We apply individualized Cognitive-Behavioral Therapy for Insomnia (CBT-I) based on the consensus recommendations of a number of key organizations including the National Institutes of Health, the American Academy of Sleep Medicine, and the American College of Physicians.

Other sleep problems we commonly help to resolve include circadian rhythm disorders (related to shift work, irregular or delayed sleep patterns, etc.), hypersomnia, nightmares, night eating, sleep or nighttime related fears and anxiety, and difficulty tolerating CPAP for sleep apnea.

A full course of treatment with a BSM Specialist usually spans several appointments -- on average between 3-5 visits. However, each individual is different and it may take some patients more or less time to meet their sleep-related goals.

If you have any questions regarding your appointment, please call 708-364-0261 and follow the prompts to speak with a member of our scheduling staff. Please also feel free to review the section on Behavioral Sleep Medicine on our website (www.sleepmedcenter.com), including the Frequently Asked Questions. We look forward to meeting with you!

Patient Name: _____ Date of Birth: _____

Initial Sleep Log

For the week prior to your appointment, please complete the sleep log **each morning for the night before**.

******Please do not check the time (using a clock, phone, FitBit, etc.) in order to complete the log; instead, just provide a rough estimate based on what it felt like to you – all times will be considered approximate.***

	Example	**Night 1**	**Night 2**	**Night 3**	**Night 4**	**Night 5**	**Night 6**	**Night 7**
Indicate the date and day of the week:	*10/5 Monday*							
A. What time did you physically get into bed (last night)?	*9:45 PM*							
B. At about what time did you engage sleep effort or "try" to go to sleep? (i.e., when you turned out the light, put your head on the pillow, stopped reading)	*10:00 PM*							
C. Estimate how long it took you to fall asleep once trying to do so:	*45 min.*							
D. Once asleep, about how many times did you wake (not including the final time)?	*2*							
E. Estimate the total amount of time you were awake during all of your awakenings combined:	*80 min.*							
F. At about what time did you wake for the final time (before getting out of bed)?	*7:00 AM*							
G. What time did you get out of bed to rise for the day?	*7:30 AM*							
H. How rested did you feel when getting out of bed? 1 = "not at all rested" to 10 = "very rested"	*3*							
I. How rested did you feel one hour after getting out of bed? 1 = "not at all rested" to 10 = "very rested"	*5*							
J. Please rate your overall daytime functioning yesterday: 1 = "very poor" to 10 = "excellent"	*6*							
K. Estimate the total amount of time you napped yesterday (intentionally or unintentionally) and when these naps occurred:	*60 min. 1:30pm*							
L. List any over-the-counter or prescription sleep medications you took last night and the dosage:	*zolpidem 5 mg*							

Initial Evaluation Questionnaire

Patient Name: _____ Date of Birth: _____ Date: _____

Sleep Problem and Severity Assessment

Below are questions which help us assess the nature and severity of your sleep problem. We want to know about the current nature of your difficulty – meaning, *within the last two weeks:*

1. Rate the *current* severity of your sleep problem:

	Not Applicable	Mild	Moderate	Severe	Very Severe
a. Difficulty falling asleep	☐	☐	☐	☐	☐
b. Difficulty staying asleep	☐	☐	☐	☐	☐
c. Problems waking too early	☐	☐	☐	☐	☐
d. Poor sleep quality	☐	☐	☐	☐	☐
e. Sleeping too little or too much *(please circle)*	☐	☐	☐	☐	☐
f. Falling asleep during the day (e.g. napping)	☐	☐	☐	☐	☐
g. Problematic sleep schedule (e.g. irregular pattern, sleeping in too late)	☐	☐	☐	☐	☐
h. Unwanted behavior during sleep (e.g. sleepwalking)	☐	☐	☐	☐	☐
i. Nightmares or vivid dreams *(please circle)*	☐	☐	☐	☐	☐
j. Other (*please specify*): _____	☐	☐	☐	☐	☐

2. How long does it usually take you to fall asleep? _____ *minutes/hours*

3. How many times do you wake up during the night? _____

4. How long are you usually awake after waking up at night? _____ *minutes/hours*

5. How often during a week do you nap or doze? _____

6. On how many nights during an average week do you experience sleep difficulties? _____

	Not at All	A Little	Some	Much	Very Much
7. How dissatisfied are you with your *current* sleep pattern?	☐	☐	☐	☐	☐
8. How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?	☐	☐	☐	☐	☐
9. How worried/distressed are you about your *current* sleep problem?	☐	☐	☐	☐	☐
10. To what extent do you consider your problem to interfere with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) *currently*?	☐	☐	☐	☐	☐

11. How long have you experienced sleep difficulties? _____

12. Was there any event or life situation that seems to have occurred around the time your sleep difficulties emerged? Is there anything you feel caused or worsened your sleep difficulty? Yes ☐ No ☐

If yes, please briefly describe: _____

_____

Contributing Factors

Rate the extent to which you feel the following factors may contribute to your sleep difficulties:

	Not at All	A Little	Some	Much	Very Much
a. Mental activity (i.e., mind won't "shut off," racing thoughts, worry about sleep)	☐	☐	☐	☐	☐
b. Physical discomfort (e.g., pain, muscle tension)	☐	☐	☐	☐	☐
c. Poor sleep habits (e.g., heavy caffeine use, spending waking hours in bed)	☐	☐	☐	☐	☐
d. Mood (e.g. depression, anxiety)	☐	☐	☐	☐	☐
e. Natural aging (e.g., menopause, prostate issues)	☐	☐	☐	☐	☐
f. A variable sleep schedule (i.e., due to shift work or lifestyle)	☐	☐	☐	☐	☐
g. Personal stressors (e.g., relationships, family domain)	☐	☐	☐	☐	☐
h. Work stressors (e.g., work demands, job security)	☐	☐	☐	☐	☐
i. Weight gain or loss	☐	☐	☐	☐	☐
j. Medication(s)	☐	☐	☐	☐	☐
k. Medical condition(s)	☐	☐	☐	☐	☐
l. Travel schedule (e.g., jet lag)	☐	☐	☐	☐	☐
m. Other *(please specify)*: _____	☐	☐	☐	☐	☐

Current and Prior Treatment Efforts

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

	Past Use	Current Use
1. Over-the-Counter sleep aids (e.g., Tylenol PM, Unisom, ZzzQuil)	☐	☐
2. Prescription sleep aids:		
a. Lunesta (eszopiclone)	☐	☐
b. Ambien (zolpidem)	☐	☐
c. Ambien CR (zolpidem ER)	☐	☐
d. Rozerem (ramelteon)	☐	☐
e. Sonata (zaleplon)	☐	☐
f. Belsomra (suvorexant)	☐	☐
g. Trazodone	☐	☐
h. Benzodiazepines (e.g., lorazepam, Xanax, Klonopin)	☐	☐
i. Seroquel (quetiapine)	☐	☐
j. Minipress (prazosin)	☐	☐
k. Other prescription medications:	☐	☐
3. Alcohol	☐	☐
4. Melatonin	☐	☐
5. Herbal supplements/tea (e.g., gingko biloba, valerian root)	☐	☐
6. Other controlled substances (e.g., marijuana)	☐	☐
7. Self-help literature (e.g., books, pamphlets about insomnia)	☐	☐
8. Relaxation exercises/yoga/meditation	☐	☐
9 Cognitive Behavioral Therapy (CBT)	☐	☐
10. Psychotherapy/counseling	☐	☐
11. Other (acupuncture, massage, etc.- *please specify)* _____	☐	☐

Beliefs and Attitudes About Your Sleep (DBAS – 16)

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 Disagree		Disagree		Neutral		Agree		Strongly Agree	
1.	I need 8 hours of sleep to feel refreshed and function well during the day.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	I am concerned that chronic sleep difficulties may have serious consequences for my physical health.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	I am worried that I may lose control over my abilities to sleep.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	After a poor night's sleep, I know that it will interfere with my daily activities on the next day.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	When I feel irritable, depressed or anxious during the day, it is because I did not sleep well the night before.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	When I sleep poorly on one night, I know it will disturb my sleep schedule for the whole week.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	Without an adequate night's sleep, I can hardly function the next day.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	I can't ever predict whether I'll have a good or poor night's sleep.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	I have little ability to manage the negative consequences of disturbed sleep.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.	I believe my sleep difficulties are essentially the result of a chemical imbalance.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14.	I feel my sleep difficulties are ruining my ability to enjoy life and prevent me from doing what I want.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15.	A "nightcap" before bedtime is a good solution to sleep problems.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16.	It usually shows in my physical appearance when I haven't slept well.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

General Anxiety (GAD – 7) and 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.

1. Over the ***last 2 weeks***, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
a. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
b. Not being able to sleep or control worrying	☐	☐	☐	☐
c. Worrying too much about different things	☐	☐	☐	☐
d. Trouble relaxing	☐	☐	☐	☐
e. Being so restless that it is hard to sit still	☐	☐	☐	☐
f. Becoming easily annoyed or irritable	☐	☐	☐	☐
g. Feeling afraid, as if something awful could happen	☐	☐	☐	☐
h. Little interest or pleasure in doing things	☐	☐	☐	☐
i. Feeling down, depressed or hopeless	☐	☐	☐	☐
j. Trouble falling or staying asleep; sleeping too much	☐	☐	☐	☐
k. Feeling tired or having little energy	☐	☐	☐	☐
l. Poor appetite or overeating	☐	☐	☐	☐
m. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
n. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
o. 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	☐	☐	☐	☐
p. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any of the above problems, 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

Brief PHQ (continued)

		Not Applicable	Not Bothered	Bothered a Little	Bothered a Lot
2.	In the ***last 4 weeks***, how much have you been bothered by any of the following problems?				
	a. Worrying about your health	☐	☐	☐	☐
	b. Your weight or how you look	☐	☐	☐	☐
	c. Little or no sexual desire or pleasure during sex	☐	☐	☐	☐
	d. Difficulties with your husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐	☐
	e. The stress of taking care of children, parents, or other family members	☐	☐	☐	☐
	f. Stress at work, outside of the home, or at school	☐	☐	☐	☐
	g. Financial problems or worries	☐	☐	☐	☐
	h. Having no one to turn to when you have a problem	☐	☐	☐	☐
	i. Something bad that happened recently	☐	☐	☐	☐
	j. Thinking or dreaming about something terrible that happened to you *in the past* – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐	☐
3.	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?	☐	☐	☐	☐

4. What is the most stressful thing in your life right now? _____

_____

_____

Medical Conditions and Medications

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

_____

_____

_____

_____

_____