Regions Hospital®

SLEEP HEALTH CENTER

Sleep Health Center

You have been scheduled for an Insomnia Treatment Program consultation to further discuss your sleep. In the week preceding your appointment, please take the time to complete the enclosed Insomnia Treatment Program Intake Form and related questionnaires.

Please bring these completed forms with you to your appointment. We look forward to helping you to improve the quality of your sleep, and thank you for taking the time to complete this information.

APPOINTMENT INFORMATION:

PROVIDER:_____

DATE:_____

TIME:_____

LOCATION: Regions Hospital Sleep Health Center
2688 Maplewood Drive
Maplewood, MN 55109-1021

PHONE: 651-254-8150

FAX: 651-481-4951

CBT-I Questionnaire

Name:_____ DOB:_____ Today's Date:_____

Address:_____

Marital Status: Single Married Divorced Separated Widowed Partnered

Children's names/ages: _____

_____

People living with you: _____

Where were you born? _____ Where were you raised? _____

What schools have you attended? _____

Are you currently a student? Yes No If yes, what school? _____

Are you employed? Yes (Full-time Part-time Temporary) No

Current or most recent occupation:_____

Do you use: **Tobacco** No Yes **Caffeine** No Yes
Alcohol No Yes **Recreational drugs** No Yes

How many days per week do you engage in formal exercise? 0 1 2 3 4 5 6 7

How satisfied are you with your social support? (0=not happy; 10 = very happy) ____/10

Have you ever had an overnight sleep study? Yes No Do you currently use CPAP or an oral appliance? Yes No

Have you ever seen a psychiatrist, psychologist, therapist, or counselor? Yes No

Are you currently seeing a psychiatrist, psychologist, therapist, or counselor? Yes No

Have you ever been hospitalized for psychiatric or emotional problems? Yes No

Have you ever been treated for chemical dependency or abuse? Yes No

Please describe how much distress you have been experiencing in the past week including today:

(***None***) 0 1 2 3 4 5 6 7 8 9 10 (***Extreme***)

What recent stressors are you dealing with? _____

Length of current sleep problems: 0-3 months 3-12 months 1-5 years 5-10 years 10-20 years > 20 years

Were there any specific events/causes that you are aware of? _____

_____

Are the sleep problems: getting worse stable/not changing recently improving episodic

Are you aware of a family history of sleep problems? _____

Sleep Habits (answer these questions based on the past 3 months, with "night" meaning your usual sleeping time)

What are you typically doing **before** getting into bed:_____

What time do you typically **get into** the bed on weekdays or days that you work? _____ to _____ am/pm

How many nights per week do you have difficulty *falling* asleep? 0 1 2 3 4 5 6 7

How many minutes until you are asleep **after getting into** your bed? 0-5' 5-20' 20-60' 60-120' 120-240' >240'

What are you doing while in the bed? (TV read listen to music eat text work talk on phone computer use)

After first falling asleep, how often do you wake up and fall back to sleep? 0-1x 2-3x 4-5x 5-10x >10x

How many <u>total</u> minutes are you awake, as a result of your awakenings? 0-5' 5-10' 10-30' 30-60' 60-120' >120'

What do you do when awake in the middle of the night? (read TV music eat work phone/computer stay in bed)

What types of things wake you up? _____

How many mornings do you wake up too early and have difficulty returning to sleep? 0 1 2 3 4 5 6 7

What else do you do when this happens? (read TV music eat work phone/computer stay in bed)

What time do you typically **get out of** bed to start the day? _____ to _____am/pm

Do you keep a regular sleep schedule? Yes No Is your sleep schedule different on week-ends? Yes No

How would you rate your sleep quality on a scale of 0-10? (0=lowest quality and 10=highest quality): _____/10

How much does poor sleep impair your daily functioning? (0= none, 10=completely impairs me): _____/10

How many days per week do you take a nap: 0 1 2 3 4 5 6 7 Typical nap length: _____

Do you currently do shift work? Yes No Have you done shift work in the past? Yes No

If you could set your own sleep schedule: What time would you go to sleep? _____ am pm

What time would you get up? _____ am pm

Please list all prescription sleep medications you are taking: _____

_____

Please list anything else you take to help your sleep: _____

How many nights per week do you use a sleep medicine? _____ Is your sleep disrupted by your bed partner? Yes No

What sleep medications have you taken in the past? _____

Is your bedroom: Dark Cool Quiet Comfortable bed Do you feel safe and secure where you sleep? Yes No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. 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 = No chance of dozing 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, i.e., a theater or 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 stopped for a few minutes in traffic	_____
TOTAL:	_____

Insomnia Severity Index

For each question, please circle the number that best describes your answer.
Please rate the current (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problems waking up too early	0	1	2	3	4

How **SATISFIED/DISSATISFIED** are you with your **CURRENT** sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

How **NOTICEABLE** to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

How **WORRIED/DISTRESSED** are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, mood ability to function at work/daily chores, concentration, memory, mood, etc.) **CURRENTLY**?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

FSI

For each of the following, circle the <u>one number</u> that best indicates how that item applies to you.

1. Rate your level of fatigue on the day you felt **most** fatigued during the past week:

0	1	2	3	4	5	6	7	8	9	10
Not at all Fatigued										**As fatigued as I could be**

2. Rate your level of fatigue on the day when you felt **least** fatigued during the past week:

0	1	2	3	4	5	6	7	8	9	10
Not at all Fatigued										**As fatigued as I could be**

3. Rate your level of fatigue on the average during the past week:

0	1	2	3	4	5	6	7	8	9	10
Not at all Fatigued										**As fatigued as I could be**

4. Rate your level of fatigue right now:

0	1	2	3	4	5	6	7	8	9	10
Not at all Fatigued										**As fatigued as I could be**

5. Rate how much, in the past week, fatigue interfered with your **general level of activity**:

0	1	2	3	4	5	6	7	8	9	10
No interference										**Extreme interference**

6. Rate how much, in the past week, fatigue interfered with your **ability to bathe and dress yourself**:

0	1	2	3	4	5	6	7	8	9	10
No interference										**Extreme interference**

7. Rate how much, in the past week, fatigue interfered with your **normal work activity (includes both work outside the home and housework)**:

0	1	2	3	4	5	6	7	8	9	10
No interference										**Extreme interference**

8. Rate how much, in the past week, fatigue interfered with your **ability to concentrate**:

0	1	2	3	4	5	6	7	8	9	10
No interference										**Extreme interference**

FSI

For each of the following, circle the <u>one number</u> that best indicates how that item applies to you.

9. Rate how much, in the past week, fatigue interfered with your **relations with other people**:

0	1	2	3	4	5	6	7	8	9	10
No interference										**Extreme interference**

10. Rate how much, in the past week, fatigue interfered with your **enjoyment of life**:

0	1	2	3	4	5	6	7	8	9	10
No interference										**Extreme interference**

11. Rate how much, in the past week, fatigue interfered with your **mood**:

0	1	2	3	4	5	6	7	8	9	10
No interference										**Extreme interference**

12. Indicate **how many days**, on average, you felt fatigued in the past week:

0	1	2	3	4	5	6	7
Days							Days

13. Rate **how much of the day**, on average, you felt fatigued in the past week:

0	1	2	3	4	5	6	7	8	9	10
None of The day										The entire day

14. Indicate which of the following best describes the **daily pattern** of your fatigue in the past week:

0	1	2	3	4
Not at all Fatigued	Worse in the morning	Worse in the afternoon	Worse in the evening	No consistent daily pattern of fatigue

GAD-7

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several Days	Over 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's 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 (add your column scores)				
If you checked off any problems, how difficult have these 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

PHQ-9

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

	Not at all	**Several days**	**More than half of the days**	**Nearly every day**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling asleep, staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
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	**0**	**1**	**2**	**3**
Thinking that you would be better off dead or that you want to hurt yourself in some way	**0**	**1**	**2**	**3**
TOTALS:				
	Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
If you checked off any problem on the above 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?	**0**	**1**	**2**	**3**

Quality of Life

In general, how would you describe your health? (Circle One)

Excellent | Very Good | Good | Fair | Poor

How stressful do you rate your life? (Circle One)

Low Stress | Somewhat Stressed | Extremely Stressed

How effectively do you deal with Stress in your life? (Circle One)

Very Effectively | Somewhat Effectively | Not at all Effectively

During the past four weeks, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health? (Circle One)

None | A Little Bit | Some | Quite a Bit | I could not do my daily work because of my physical health

During the past four weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems, such as feeling depressed or anxious? (Circle One)

Not at all | Slightly | Moderately | Quite a bit | Extremely

How often do you feel depressed? (Circle One)

Never | Sometimes | Most of the time

In the past year, have you been physically abused – such as hit, kicked or choked? (Circle One)

Yes | No | Choose not to answer

In the past year, have you been verbally or emotionally abused – such as threatened, intimidated, insulted, or controlled? (Circle One)

Yes | No | Choose not to answer

MFSI-SF

Below is a list of statements that describe how people sometimes feel. Please read each item carefully, then circle the one number next to each item which best describes **how true each statement has been for you in the past 7 days.**

		Not at all	A little	Moderately	Quite a bit	Extremely
1.	I have trouble remembering things	0	1	2	3	4
2.	My muscles ache	0	1	2	3	4
3.	I feel upset	0	1	2	3	4
4.	My legs feel weak	0	1	2	3	4
5.	I feel cheerful	0	1	2	3	4
6.	My head feels heavy	0	1	2	3	4
7.	I feel lively	0	1	2	3	4
8.	I feel nervous	0	1	2	3	4
9.	I feel relaxed	0	1	2	3	4
10.	I feel pooped	0	1	2	3	4
11.	I am confused	0	1	2	3	4
12.	I am worn out	0	1	2	3	4
13.	I feel sad	0	1	2	3	4
14.	I feel fatigued	0	1	2	3	4
15.	I have trouble paying attention	0	1	2	3	4
16.	My arms feel weak	0	1	2	3	4
17.	I feel sluggish	0	1	2	3	4
18.	I feel run down	0	1	2	3	4
19.	I ache all over	0	1	2	3	4
20.	I am unable to concentrate	0	1	2	3	4
21.	I feel depressed	0	1	2	3	4
22.	I feel refreshed	0	1	2	3	4
23.	I feel tense	0	1	2	3	4
24.	I feel energetic	0	1	2	3	4
25.	I make more mistakes than usual	0	1	2	3	4
26.	My body feels heavy all over	0	1	2	3	4
27.	I am forgetful	0	1	2	3	4
28.	I feel tired	0	1	2	3	4
29.	I feel calm	0	1	2	3	4
30.	I am distressed	0	1	2	3	4

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

		1	2	3	4	5
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example: festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometer (or equivalent 6/10ths of a mile)?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

TOTAL: _____

H1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days _____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days _____
H3	In the past 30 days, not counting the days that you were totally unable, for many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days ____