Vicki Paulus, MN, ARNP, LLC
Phone: 360-571-2050 Fax: 360-253-3196

7600 NE 41st St, Suite 310
Vancouver, WA 98662

Patient Face Sheet:

Please complete all information on this form and bring it to the first visit.

Today's date:_____

Patient's full name:_____

Date of Birth (DOB):_____Sex:_____ Marital Status:_____

Address:_____

Mailing Address (if different):_____

City:_____ State:_____ Zip Code:_____

Home phone:_____ Ok to leave message: Yes ____ No ____

Alternate phone:_____ Ok to leave message: Yes ____ No ____

Length at present address:_____ Social Security #:_____

E-mail:_____

Emergency Contact:_____

Home Phone:_____ Alternate Phone:_____

This will be used for billing your insurance:

Responsible party:_____ DOB:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Social Security #:_____

Employer:_____ Employer's phone:_____

Employer's address:_____

City:_ _____State:_____ Zip Code: _____

Spouse of responsible party:_____ DOB:_____

Address: _____

City:_____ State:_____ Zip

Code:_____

Social Security #:_____

Employer:_____ Employer's phone:_____

Employer's address:_____

City:_____ State:____ Zip Code: _____

Insurance Information	
Primary Insurance Name:	Secondary Insurance Name:
Phone # on card for providers:	Phone # on card for providers:
Employer:	Employer:
Subscriber's name:	Subscriber's name:
Subscriber's DOB:	Subscriber's DOB:
Patient's relationship to subscriber:	Patient's relationship to subscriber:
Subscriber's address:	Subscriber's address:
City, State, Zip Code:	City, State, Zip Code:
Patient's address (if different):	Patient's address (if different):
City, State, Zip Code:	City, State, Zip Code:
Group Number:	Group Number:
ID Number (include letters):	ID Number (include letters):

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Vicki Paulus, MN, ARNP, LLC. to:

Furnish my insurance company with any/all information requested concerning my present claim(s).

Bill my insurance company and accept payment from that company on my behalf for all services from time to time relating to my case.

I acknowledge that I am responsible for all charges not covered by my insurance. I agree that if costs or fees are incurred in connection with the collection of this account, I will pay all such costs and fees, including, but not limited to, collection costs, attorney's fees, and all court costs. I understand that failure to resolve any outstanding balance may result in my account being referred to a collection agency if it remains delinquent without a response from me.

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NOTICE OF INFORMATION PRACTICES

We keep a record of the health-care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Vicki Paulus directly. The fees for copying records, searching for records, or editing records are as follows:

Copying: $1.00 per page for the first 30 pages, $1.50 for each additional page

Searching: $30.00 per record search

Editing by the physician personally: basic office visit charge when required by statute

All copies will be released only upon receipt of payment.

Patient's signature: _____ Date: _____

Responsible party's signature (Parent/Guardian if for a minor):

_____ Date: _____

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Office Policies and Procedures

This statement contains information regarding my office policies. Please read them and, if you have any questions, please discuss them with me. Your signature at the bottom of this sheet signifies you have read, understood, and agree to abide by these policies, and that you have received a copy of the policies for yourself.

APPOINTMENTS:
Appointment times vary in length depending on the service and complexity. Initial evaluations are 60-90 minutes; psychotherapy sessions are generally 30-60 minutes; medication management visits are 30 minutes.

Your appointment time is held exclusively for you and cannot usually be filled on short notice. **Unless cancelled with 48-hour advance notice, you will be charged a $150 missed appointment fee. Messages can be left on my voicemail, 24 hours a day, at 360-571-2050. If you no-show for 2 appointments within a 365-day period, the termination process may begin.**

Emergency cancellations that occur with less than 48 hours advance notice will be handled on an individual basis. Please note that insurance companies will not cover this charge and you will be responsible for covering this fee in full.

For **severe weather** events, please follow the Vancouver Public School System alerts. If the Vancouver school district is closed due to weather, my office will be closed and we will work to re-schedule you.

By consent to treatment, you agree to provide me with 7-10 days prior notice to needing a refill. Please have your pharmacy fax my office a refill request form at 360-253-3196. Medication refills are not considered an emergency. Please plan many days in advance.

INSURANCE:
We will bill your insurance for our services. However, this can only occur if you provide us with current insurance information. It is your responsibility to provide us with updated insurance in the event of a change of coverage. Co-payments are to be paid at the time of the service. We will assist you, but it is your responsibility to check with your insurance company regarding your coverage. We do not guarantee payment from your insurance company. You are responsible for bills whether insurance pays or not. If your insurance company has not paid your account in full within 90 days, the balance will be automatically due and payable by you.

FEES:

60-90 minute Initial psychiatric evaluation and diagnosis 99205	$400.00 - $550.00
30 minute psychotherapy with patient/family member with E&M service 90833	$150.00
45 minute psychotherapy with patient/family member with E & M service 90836	$200.00
60 minute psychotherapy with patient/family member with E &M service 90838	$250.00
Office visit, E & M, 15 minutes established patient 99213	$150.00
Office visit E & M 25 minutes established patient 99214	$205.00
Office visit E & M 40 minutes established patient 99215	$275.00
Interactive complexity code in addition to psychotherapy, E&M visit 90785	$20.00
Additional services (your request or benefit)	$400/hour

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PAYMENTS & INSURANCE:

1. Insurance co-payment and deductible are due at time of service.
2. It is your responsibility to provide us with current or updated insurance information.
3. You are responsible for the bills whether insurance pays or not. If your insurance company has not paid your account in full within 90 days, the balance will be automatically due and payable by you.
4. You will be billed monthly for any outstanding balance. Payment is due by the 15th of the month.
5. There is a $35 returned check fee and payment must be made immediately.
6. Seriously past-due accounts may be sent to collections or legal action may be taken.
7. You agree to be responsible for any collection or court costs or attorney fees.

Emergency Calls:

We are not equipped to handle acute emergencies. If you have a non-emergent problem and wish to speak with me leave a message at the office and I will attempt to contact, you as soon as I am able. You can also call me at (360) 903-3796. If you need immediate support for an emergency, you may contact the Crisis Line at (360) 696-9560 or visit the nearest ER. When I am unavailable, another clinician will be available again for non-emergent issues. Please plan ahead, refills of medications are **not** emergencies.

Confidentiality and the Release of Information:

By law all information you share during the evaluation, psychotherapy and medication management visits remains confidential. Such information can only be released with the written consent of the patient, or in the case of a minor, the parent or guardian.

Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: a) cases of suspected abuse or neglect of a child or elder, b) cases where I believe the client presents a clear and imminent danger to him/herself or to another person, c) cases where a court subpoenas me to testify or subpoenas my records or d) cases where an insurance company is helping to pay your fee and requires information about diagnosis and/or reports about treatment.

HIPAA Notice of Policies and Practices:

We are committed to preserving the privacy of your personal health information. Additionally, we are required by the Federal law (Health Insurance Portability and Accountability Act, known as HIPAA), and by State law to protect the privacy of your personal information and to offer you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information.

Your signature below indicates that you have read this agreement and agree to its terms. Your signature also serves as an acknowledgment that you have received the *HIPAA Notice of Policies and Practices* described above.

I HAVE READ THE ABOVE POLICIES AND AGREE WITH THE TERMS

Patient name: _____ Date: _____
(please print legibly)

Patient signature: _____ DOB: _____

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I understand that Vicki Paulus, MN, ARNP, LLC is not a contracted provider for Medicare, Medicaid, Oregon Medical Assistance Program (OMAP), Oregon Health Plan (OHP), Crime Victims or Labor and Industry. Vicki Paulus, MN, ARNP, LLC will not bill any of these agencies

These services may be available through a contracted provider. If you choose a contracted provider, these services will be paid for up to the allowable amount.

Patient's Request and Consent for Non-Medicare Services:

I provide this Request and Consent to protect my future access to private medical care based on payments using Medical Savings Accounts or other private payment methods. I request and consent that the medical office of Vicki Paulus, MN, ARNP, LLC ("this private provider") provide medical services to me outside of the Medicare and other government programs in emergency and non-emergency circumstances. I acknowledge and consent that no documentation will be provided for such services to enable reimbursement from Medicare or other governmental programs.

Neither I nor my heirs, executors, administrators, successors, beneficiaries, or assigns will submit a claim (or request that a claim be submitted) for services provided by this private physician. I acknowledge that such services may fall within the scope of Medicare or other governmental programs, and that I have the right to seek such services from other providers if I wish to obtain reimbursement by the government. I consent that the fees charged by this private physician for such services may be greater or less than limiting charges established by Medicare or other programs.

I hereby acknowledge and consent that this private physician is justified in relying upon this Request and Consent in providing all future services to me, whether during an emergency or not. In the event that I take any action contrary to this Request and Consent which causes administrative or legal expense to this private physician, I will provide reasonable reimbursement.

THIS IS <u>NOT</u> A PRIVATE CONTRACT FOR ANY ITEM OR SERVICE. THE UNDERSIGNED IS NOT OBLIGATED IN ANY MANNER TO OBTAIN ANY MEDICAL SERVICES FROM THIS PRIVATE PROVIDER AND REMAINS FREE TO SEEK MEDICAL CARE FROM ANY OTHER PROVIDER AT ANY TIME. THIS FORM IS CONFIDENTIAL AND MAY NOT BE CONSTRUED TO ALLOW DISCLOSURE OF ANY INFORMATION CONCERNING PATIENT.

I have disclosed all my insurance information, including any coverage through any of the agencies listed above.

Patient name: _____ Date: _____
(please print legibly)

Patient signature: _____ DOB: _____

HIPAA CONSENT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally , are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

**Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
**Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
**Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and service s that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authori zation in writing and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Offer.

**The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any person identifiable by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

**The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
**The right to inspect and copy your protected health information.
**The right to amend your protected health information.
**The right to receive an accounting of disclosures of protected health information.
**The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of January 1, 2017 and we are required to abide by the terms of this Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of P rivacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may requ est a written copy of the revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint:

The US Dept of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, DC 20201 202-619-0257 or 1-800-696-6775

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HIPAA CONSENT

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your right under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

-Protected health information may be disclosed or used for treatment, payment, or healthcare operation

-The practice reserves the right to change the privacy policy as allowed by law

-The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions

-The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

-The practice may condition receipt of treatment upon execution of this consent

The following are rare exceptions where pertinent health information may be shared without written consent:

-A patient is an imminent danger to themselves or others.

-A court has subpoenaed me to testify or has subpoenaed my records.

-An insurance company is helping to pay the fee and requires information about diagnosis and/or reports about treatment.

-An emergent decision needs to be made in the absence of consent but where clinical information is needed to make that decision.

This consent was signed by: _____
(PLEASE PRINT NAME)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Consent for Mental Health Evaluation and/or Treatment

Name: _____

Date of Birth: _____

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/ortreatment by staff from Vicki Paulus, MN, ARNP, LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services, including "off-label" use of medications
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable)
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a Psychiatric Nurse Practitioner. Treatment will be conducted within the boundaries of Washington Law. It is my responsibility to update my provider regarding insurance or medical/medication changes, including the use of over-the-counter medications and supplements.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles, and know I am ultimately responsible for the balance of my account for any professional services rendered. I have been provided a fee schedule with the Policies & Procedures.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Vicki Paulus, MN, ARNP, LLC, and I consent to disclosure for use by Vicki Paulus, MN, ARNP, LLC's staff for the purpose of continuity of my care. Per Washington mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; 3) if a court order is issued to obtain records; or 4) pertinent information is needed to make an emergent decision.

5. **Appointment Cancellations:** I understand I am responsible for charges accrued for missed appointments and appointment cancellations without 48-hour advanced notice unless it is a verifiable emergency. I understand my insurance company will not reimburse for missed sessions. The fee for a missed or late cancelled appointment is $150.

6. **Termination of Treatment:** Termination of treatment is usually a mutually agreed upon ending of the therapeutic relationship, but some circumstances may result in premature termination or closing of my case. Circumstances include (2) or more unexcused missed appointments within one rotating calendar year, no

office appointments scheduled within (30) days of a missed appointment, undisclosed substance use, physical threat to providers or staff, non- compliance with treatment guidelines, or no payment received on my balance over (60) days.

7. **Prescription Refills:** I agree to contact my provider for refill requests 7-10 days before the refill is needed. Prescription refills are never considered an emergency.

8. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

9. **Expiration of Consent:** This consent to treat will expire with termination of services.

By initialing here, I acknowledge that I have received a copy of Vicki Paulus, MN, ARNP, LLC's Policies and Procedures:

_____
Initials

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____
Signature of client **Date**

_____
Signature of parent or guardian/responsible party **Date**

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Informed Consent for Telehealth Services

Definition of Telehealth:
Telehealth involves the use of electronic communications to enable Vicki Paulus to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychiatric health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; expressed intent to imminently harm myself; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Vicki Paulus utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my provider believes I would be better served by another form of intervention (e.g., face-to-face services), I will be offered referrals, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to care through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my provider, I may be directed to "face-to-face" care.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
8. I understand that my express consent is required to forward my personally identifiable information to a third party.
9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based mental health services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
11. I understand that different states have different regulations for the use of telehealth and that such services offered by Vicki Paulus may be temporary based on urgent and unprescedented global circumstances.

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Payment for Telehealth Services

Vicki Paulus will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, payment at the time of service is required.

Patient Consent for the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my provider, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____
Print Name

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature for minor under 18 Date

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Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Date of Birth_____Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____Therapist's Phone_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____

What are your treatment goals?

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Increased sleep
( ) Loss of interest in usual activities
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Overwhelmed
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Hopeless
( ) Helpless
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying?_____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

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Past Medical History:

Allergies_____Current Weight_____Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

Past medical problems, non-psychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____
Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

Have you ever had a sleep study ( ) Yes ( ) No, If yes, when _____
Was the sleep study ( ) normal ( ) abnormal or ( ) unknown

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

For women only: Date of last menstrual period_____Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant?_____How many live births? _____

Personal and Family Medical History:

	You	**Family**	**Which Family Member?**
Anemia	( )	( )	_____
Asthma/Respiratory Problems	( )	( )	_____
Cancer (type)	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Chronic Pain	( )	( )	_____
Diabetes	( )	( )	_____
Epilepsy or Seizures	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart Disease	( )	( )	_____
High Blood Pressure	( )	( )	_____
High Cholesterol	( )	( )	_____
Kidney Disease	( )	( )	_____

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Personal and Family Medical History Continued:

	You	Family	Which Family Member?
Liver Disease	( )	( )	_____
Stomach or Intestinal Problems	( )	( )	_____
Other	( )	( )	_____
Other	( )	( )	_____
Other	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? _____

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants	Dates	Dosage	Response/Side-Effects
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Trintellix (vortioxetine)			
Pristiq (desventafaxin)			
Desyrel (trazodone)			

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Past Psychiatric Medications Continued:

	Dates	Dosage	Response/Side-Effects
Vibryd (vilazodone)			
Adamin (doxepin)			
Asendin (amocapine)			
Ludiomil (maprotiline)			
Norpramin (desipramine)			
Surmontil (trimipramine)			
Vivctil (protriptyline)			
Other			
Mood Stabilizers	Dates	Dosage	Response/Side--Effects
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Topamax (topiramate)			
Vraylar (Cariprazine)			
Other			
Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Rexulti (brexpiprazole)			
Latuda (lurasidone)			
Other			
Sedative/Hypnotics	Dates	Dosage	Response/Side-Effects
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			
ADHD medications	Dates	Dosage	Response/Side-Effects
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse (lisdexamfetimine)			
Other			
Antianxiety medications	Dates	Dosage	Response/Side-Effects
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			

Family Psychiatric History:

Has anyone in your **family** been diagnosed with or treated for:

ADHD/ADD	( ) Yes	( ) No	If yes, who? _____
Bipolar disorder	( ) Yes	( ) No	If yes, who? _____
Schizophrenia	( ) Yes	( ) No	If yes, who? _____
Depression	( ) Yes	( ) No	If yes, who? _____
Post-Traumatic Stress	( ) Yes	( ) No	If yes, who? _____
Alcohol Abuse	( ) Yes	( ) No	If yes, who? _____
Other substance abuse	( ) Yes	( ) No	If yes, who? _____
Anxiety	( ) Yes	( ) No	If yes, who? _____
Other	( ) Yes	( ) No	If yes, who/what? _____
Other	( ) Yes	( ) No	If yes, who/what? _____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____

Check if you have ever tried the following which were NOT prescribed for you?:

	Yes	No	If yes, how long and when did you last use
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other	( )	( )	_____

How many caffeinated beverages do you drink a day? Coffee_____Sodas_____Tea_____
Energy Drinks: _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No Do you currently smoke cigarettes? **( )** Yes **( )** No
How many packs per day on average?_____How many years? _____
How many years did you smoke?_____When did you quit? _____
Have you ever used electronic cigarettes? ( ) Yes ( ) No Do you currently use e-cigarettes? ( ) Yes ( ) No
How many electronic cigarettes per day on average?_____How many years? _____
How many years did you use e-cigarettes? _____When did you quit? _____
Pipe, cigars, or chewing tobacco: Do you currently use tobacco products? **( )** Yes **( )** No
Have you used tobacco products in the past? **( )** Yes **( )** No What kind?_____How
often per day on average?_____How many years? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where were you born? _____
Where did you grow up?_____
How would you describe your childhood?_____
_____
_____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____
_____
Have your witnesses traumatic events during your life? (car accident, war, shooting)
Please describe: _____
_____

Educational History:

Highest high school grade completed?_____Where?_____
Did you attend college?_____Where?_____Major?_____
What is your highest education level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? ( ) Yes ( ) No If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge_____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) unsure/questioning ( ) asexual ( ) other

( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

_____

List everyone who currently lives with you: _____

_____

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

_____

_____

_____

_____

_____

_____

_____

_____

Signature_____Date_____

Guardian Signature (if under age 18)_____Date_____

Emergency Contact_____Telephone # _____

For Office Use Only:

Reviewed by_____Date_____

Reviewed by_____Date _____

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THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

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What's My ACE Score?

Prior to your 18th birthday:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason ?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

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The Bipolar Spectrum Diagnostic Scale (BSDS)

Instructions:

Please read through the entire passage below before filling in any blanks.

Some individuals notice that their mood and/or energy levels shift drastically from time to time_____.

These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high_____.

During their "low" phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things they need to do_____.

They often put on weight during these periods_____.

During their low phases, these individuals often feel "blue", sad all the time, or depressed_____.

Sometimes, during these low phases, they feel hopeless or even suicidal_____.

Their ability to function at work or socially is impaired_____.

Typically, these low phases last for a few weeks, but sometimes they last only a few days_____.

Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, during which their mood and energy level feels "right" and their ability to function is not disturbed_____.

They may then notice a marked shift or "switch" in the way they feel_____.

Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do_____.

Sometimes, during these "high" periods, these individuals feel as if they have too much energy or feel "hyper"_____.

Some individuals, during these high periods, may feel irritable, "on edge", or aggressive_____.

Some individuals, during these high periods, take on too many activities at once_____.

During these high periods, some individuals may spend money in ways that cause them trouble_____.

They may be more talkative, outgoing, or sexual during these periods_____.

Sometimes, their behavior during these high periods seems strange or annoying to others_____.

Sometimes, these individuals get into difficulty with co-workers or the police, during these high periods_____.

Sometimes, they increase their alcohol or non-prescription drug use during these high periods_____.

Now that you have read this passage, please check one of the following four boxes:

( ) This story fits me very well, or almost perfectly
( ) This story fits me fairly well
( ) This story fits me to some degree, but not in most respects
( ) This story does not really describe me at all

Now please go back and put a check after each sentence that definitely describes you.

Scoring: each sentence checked is worth one point. Add 6 points for "fits me very well," 4 points for "fits me fairly well," and 2 points for "fits me to some degree."

Total Score = _____

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	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
Add the score for each column	+	+	+	
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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any 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 _____

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

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Sleep Questionnaire

Name: _____Sex: _____Age:_____Date: _____

Date of birth: _____ Height: _____Weight: _____Neck Size: _____

Main Sleep Complaints

❑ Trouble falling asleep ❑ Trouble remaining asleep

❑ Excessive sleepiness during the day

❑ Snoring

❑ Unwanted behaviors during sleep, such as _____

❑ Other, explain _____

❑ How long? _____

Prior Sleep Disorder Diagnosis or Studies

❑ I have a prior sleep diagnosis of _____ Prior sleep studies (where, when) _____

❑ I am currently prescribed: ❑ CPAP or ❑ Bilevel pressure. Settings_____

Oxygen during the ❑ day or ❑ night_____liters per minute.

❑ Yes ❑ No I have had surgery for a sleep disorder ❑ UPPP ❑ Tonsillectomy.

❑ Other _____

❑ Yes ❑ No I use a dental device for sleep disordered breathing

Sleep Pattern

Typical bedtime:_weekday_____weekend

Typical awakening time:_weekday_____weekend

Typical hours in bed:____hours. Typical hours of sleep:___hours

Typical amount of time it takes to fall asleep_____hours

Typical number of awakenings per night _____Time it takes to fall back asleep after awakening _____

❑ Yes ❑ No My sleep pattern is irregular.

❑ Yes ❑ No I awaken early in the morning still tired but unable to return to sleep.

Sleep Environment Habits

Typical sleep position(s) ❑ back ❑ side ❑ stomach ❑ head elevated ❑ in a chair

❑ I sleep alone. ❑ I share a bed with someone.

My bedroom is ❑ comfortable ❑ noisy ❑ too warm ❑ too cold

❑ Yes ❑ No I have pets in the bedroom.

❑ Yes ❑ No I watch TV in bed prior to sleep.

❑ Yes ❑ No I read in bed prior to sleep.

❑ Yes ❑ No I work or study in bed.

❑ Yes ❑ No I drink alcohol prior to bedtime.

❑ Yes ❑ No I smoke prior to bedtime or when I awaken during the night.

❑ Yes ❑ No I eat a snack at bedtime.

❑ Yes ❑ No I eat if I awaken during the night.

Breathing

❑ Yes ❑ No I have been told that I snore ❑ loudly.

❑ Yes ❑ No I have been told that I stop breathing while asleep.

❑ Yes ❑ No I have been told that I snore only when sleeping on my back.

❑ Yes ❑ No I have been awakened by my own snoring.

❑ Yes ❑ No I awaken at night choking or gasping for air.

❑ Yes ❑ No I awaken short of breath.

❑ Yes ❑ No I have trouble breathing when flat on my back.

❑ Yes ❑ No I have trouble breathing through my nose.

❑ Yes ❑ No I have morning headaches.

❑ Yes ❑ No I sweat a great deal at night.

Daytime Sleepiness

❑ Yes ❑ No I often feel drowsy during the day, more than I expect is normal.

❑ Yes ❑ No I feel unrefreshed or tired in the morning despite sleeping at night.

❑ Yes ❑ No I take I daytime naps. How many?

❑ Yes ❑ No I have uncontrollable urges to fall asleep during the day.

❑ Yes ❑ No I have experienced lapses in time or blackouts.

❑ Yes ❑ No I have fallen asleep while driving.

❑ Yes ❑ No I performed poorly in school or work because of sleepiness.

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale and indicate 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 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 with someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL (Range of 0 to 24)	_____

Restless Leg Syndrome

❑ Yes ❑ No I kick or jerk my legs excessively during sleep. ❑ This bothers my bed partner.

❑ Yes ❑ No I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.

❑ Yes ❑ No I experience an inability to keep my leg still prior to falling asleep.

❑ Yes ❑ No I experience the feeling of restlessness in my legs at night.

Orexin Related

❑ Yes ❑ No I experience sudden muscle weakness in response to emotions such as laughter, anger or surprise.

❑ Yes ❑ No I experience an inability to move while falling asleep or when waking up.

❑ Yes ❑ No I have experienced hallucinations or dreamlike images when falling asleep or waking up.

❑ Yes ❑ No I frequently dream during daytime naps.

Parasomnias

❑ Yes ❑ No I act on my dreams while asleep.

❑ Yes ❑ No I have frequent nightmares.

❑ Yes ❑ No I talk in my sleep.

❑ Yes ❑ No I have sleep walked as an adult.

Miscellaneous (Circadian, GERD, Depression, Enuresis, Bruxism, Pain)

❑ Yes ❑ No I frequently travel across two or more-time zones.

❑ Yes ❑ No I am more alert in the morning than evening.

❑ Yes ❑ No I am more alert in the evening than morning.

❑ Yes ❑ No I awaken alert in the morning earlier than it is time to get up.

❑ Yes ❑ No I frequently have heartburn or acid reflux at night.

❑ Yes ❑ No I feel depressed.

❑ Yes ❑ No Chronic pain interferes with my sleep.

❑ Yes ❑ No The need to urinate frequently interrupts my sleep.

❑ Yes ❑ No I grind my teeth in my sleep.

❑ Yes ❑ No I have bedwetting (enuresis).

Insomnia

❑ Yes ❑ No I have trouble falling asleep.

❑ Yes ❑ No Thoughts start racing through my mind when I try to fall asleep.

❑ Yes ❑ No I have trouble remaining asleep.

❑ Yes ❑ No I awaken frequently during the night.

❑ Yes ❑ No I have difficulty returning to sleep if I awaken during the night.

Habits

❑ Yes ❑ No I smoke cigarettes (or other tobacco). If yes, how much?_____

❑ Yes ❑ No I drink alcohol. If yes, how much and how often? _____

❑ Yes ❑ No I drink caffeinated beverages during the day___cups/bottles/cans ❑ tea ❑ coffee ❑ soda per day

Social History

Marital status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Employment status: ❑ Employed: Occupation _____

❑ Unemployed ❑ Disabled ❑ Student ❑ Retired

❑ Yes ❑ No I regularly work night shifts.

❑ Yes ❑ No I work rotating shifts, including night shiftwork.

Past Medical History

❑ Hypertension ❑ Coronary artery disease ❑ Congestive heart failure ❑ Stroke ❑ Seizures

❑ COPD/asthma ❑ Diabetes ❑ Cancer ❑ Thyroid problems ❑ Depression or anxiety

❑ Alcoholism or chemical dependency ❑ Sinus disease ❑ Allergic rhinitis/nasal congestion

❑ Nasal fracture ❑ Reflux (GERD) ❑ Stomach or colon problems ❑ Fibromyalgia

❑ Back or joint problems (arthritis)

❑ Other _____

Female ❑ Premenstrual syndrome ❑ Menopause

Male ❑ Prostate problems ❑ Erectile dysfunction

Prior surgeries _____

Weight change during the past year ❑ gained_____pounds ❑ lost_____pounds

Family History

Has an immediate blood relative had any of the following?

❑ Obstructive sleep apnea ❑ Narcolepsy ❑ Other sleep disorders? _

_____