Appendix C: CBTI VA Intake Form

Patient name:______________________________ Date: ____________________ Marital status:________

Gender: ______________________________ Last 4 SSN #: ______________ Children: ________

Date of birth: ____________________________ Occupation: ______________________________

Presenting problem: What is most distressing/disturbing about current sleep?

____ Difficulty initiating sleep ____ Difficulty maintaining sleep

____ Early morning awakening ____ Difficulties waking at intended time

Comments: ____

____

Sleep habits (focus on a recent typical week):

Beginning of Sleep Period:

If different:		Weekend
Time to bed (obtain range and weekday/weekend times):	____________	____________
Time of lights out:	____________	____________
Average time to fall asleep:	____________	____________

What you do when you cannot sleep? ____

____

Pre-bedtime activities: ____

____

Pre-sleep arousal: Rumination worry physical tension fears

____

____

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

____

Middle of the night:

If different:		Weekend
Number of awakenings after sleep onset:	____________	____________
Total time awake after sleep onset:	____________	____________

(Average/worst/timing of prolonged wakefulness): ______________________________

____

What happens when awake in the middle of the night (thoughts/behaviors): ____

____

End of the night:

Final wake time: ______________ ______________

Time out of bed: ______________ ______________

Early morning awakenings (within 1 to 3 hours of intended wake time): ______________________________

How much earlier than intended? ______________ ______________

Number of days a week: ______________ ______________

Difficulties waking up at intended time: ______________ ______________

Estimated average total sleep time: ______________ ______________

Naps

Ability to nap if given an opportunity: Yes / No

If napping: Frequency ______________ duration ______________ timing ______________

Daytime effects:

Energy/fatigue: ______________ Concentration/functioning: __________ Mood: ______________

Other ____

Daytime activity levels: ____

History:

When did the problem start? ____

____

Identifiable precipitating factor: ____

____

Family history of insomnia and other sleep disorders: _________________________________

____

Circadian tendencies (circadian rhythm questionnaire and interview):

_____ Morning type _____ Neither type _____ Evening type Evidence: ____________________________

____

Sleep medication(s)/aids:

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

Obstructive sleep apnea (OSA) symptoms: STOP questionnaire score _______

___ Snoring ___Gasping/snorting ___ Witnessed apnea ___ Daytime sleepiness

PLM/RLS symptoms: ___ Leg jerks, twitches (witnessed) ___Aching, tingling creeping ___ Moving for relief

RLS questionnaire score (if administered): ___

Parasomnia symptoms: Recent frequency

Nightmares: ____

Other unusual behaviors during sleep: ____

____

Substances

Caffeine ____________________ Nicotine ____________________

Alcohol ____________________ Recreational drugs ____________________

____

Unhealthy sleep practices:

Nocturnal eating ____________________ Timing of exercise ____________________

Unusual aspects of sleep environment (bed partner, childcare, pets, comfort, sound, lights, safety, temperature): ____________

____

Medical comorbidities: ____

____

Psychiatric comorbidities: ____

____

Other medications (non-VA):

Name	Reason prescribed	Dosage	How long?

Goal: ____

____

Suggested citation: Adapted from the "Insomnia Intake Form" created by Rachel Manber for the Insomnia & Behavioral Sleep Medicine Program at Stanford University (unpublished); reprinted with her permission to the VA Cognitive Behavioral Therapy for Insomnia Training Program.