CBTI VA Intake Form – Adults

Patient name: **Date:** **Marital status:**
Gender: **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 1-3 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:

_____