CBTI VA Intake Form – Adults

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<tr>
<th>Patient name:</th>
<th>Date:</th>
<th>Marital status:</th>
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<tbody>
<tr>
<td>Gender:</td>
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<td>Children:</td>
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<tr>
<td>Date of birth:</td>
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<td>Occupation:</td>
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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:

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<tr>
<th>Name</th>
<th>Dose</th>
<th>Manner used (@ BT, Middle of night; PRN)</th>
<th>How long?</th>
<th>Helpful?</th>
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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):

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<th>Name</th>
<th>Reason prescribed</th>
<th>Dosage</th>
<th>How long?</th>
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Goal:

_______________________________________________________________________________________