Valley Sleep Center
A Night and Day Difference!

PHONE: (480) 830-3900
FAX: (480) 830-3901
valleysleepcenter.com

Insomnia Consult Form

Name: _____ DOB: _____ Date: _____

Social History

☐ **No changes since last visit**

Do you smoke? ☐ No ☐ Yes, list type of product: _____

Are you a former tobacco user? ☐ Yes ☐ No

Do you use tobacco products? ☐ No ☐ Yes, list type of product: _____

Do you drink alcohol? ☐ No ☐ Yes, how often? ☐Daily ☐Weekly ☐Monthly ☐Yearly ☐History of alcoholism

If you are over the age of 65 or a woman, how many times in the year have you had more than 4 drinks in a day? _____

If you are a male and under the age of 65, how many times in the year have you had more than 5 drinks in a day? _____

Do you use or drink caffeine products? ☐ No ☐ Yes, list type: _____ list servings per day: _____

Do you use recreational drugs? ☐ No ☐ Yes, list type: _____

Do you use medical marijuana? ☐ No ☐ Yes, list type: _____

Medical History (Mark all that apply)

☐ **No Changes Since Last Visit**
☐**No Medical History**

☐Acid Reflux or GERD	☐Allergies or Allergic Rhinitis	☐Anxiety
☐Arthritis	☐Asthma	☐Bipolar Disorder
☐Cardiac Arrhythmias	☐Central Sleep Apnea	☐Chronic Pain
☐Coronary Artery Disease	☐COPD	☐Depression
☐Diabetes Mellitus	☐Eating Disorder	☐Enlarged Tonsils/Hypertrophy
☐Enuresis/Urinating in Sleep	☐Excessive Daytime Sleepiness	☐Head Injury
☐Heart Attack	☐Heart Failure	☐HBP/Hypertension
☐High Cholesterol	☐Hypoxemia	☐Idiopathic Hypersomnia
☐Insomnia	☐Insufficient Sleep	☐Iron Deficiency
☐Kidney Disease	☐Memory Loss	☐Myocardial Infarction/Heart Attack
☐Narcolepsy	☐Nightmares	☐Night Terrors or Night Arousals
☐ Obesity	☐Obstructive Sleep Apnea	☐Palpitations
☐Peripheral Neuropathy	☐Post-Traumatic Stress Disorder	☐Restless Legs Syndrome
☐Sciatica	☐Seizures	☐Shift Work Disorder
☐Sleep Talking/Somnambulism	☐Sinus Problems/Sinusitis	☐Stroke or CVA
☐Teeth Grinding/Bruxism	☐Thyroid Disorder/Type: _____	
☐Cancer - Type: _____	☐Other: _____	

Medications (Notate dosage)

☐ **No Medication changes since last visit**

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

Allergies

☐ No known allergies

List Allergies: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

0= Would never fall Sleep 1= Slight chance of dozing 2= Moderate Chance of dozing 3= High chance of dozing

Situation	Chance of Dozing
Sitting and reading	☐0 ☐1 ☐2 ☐3
Watching TV	☐0 ☐1 ☐2 ☐3
Sitting in a public place (i.e., theater or a meeting)	☐0 ☐1 ☐2 ☐3
As a passenger in a car for an hour without a break	☐0 ☐1 ☐2 ☐3
Lying down to rest in the afternoon when circumstances permit	☐0 ☐1 ☐2 ☐3
Sitting and talking to someone	☐0 ☐1 ☐2 ☐3
Sitting quietly after a lunch without alcohol	☐0 ☐1 ☐2 ☐3
In a car, while stopped for a few minutes in traffic	☐0 ☐1 ☐2 ☐3
Epworth Sleepiness Scale Total=	

Function Outcomes of Sleep Questionnaire (FOSQ)

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised. **Directions**: Please put a mark in the box for your answer to each question. Select only ONE answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

	(0) **I don't do this activity for other reasons**	(4) **No Difficulty**	(3) **Yes, a little difficulty**	(2) **Yes, Moderate Difficulty**	(1) **Yes, Extreme Difficulty**
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?	☐	☐	☐	☐	☐
2. Do you generally have difficulty remembering things because you are sleepy or tired?	☐	☐	☐	☐	☐
3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐
4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐
5. Do you have difficulty visiting with your family or friend in their home because you become sleep or tired?	☐	☐	☐	☐	☐
6. Has your relationship with family, friends, or work with family, friends, or work colleagues been affected because you are sleepy or tired?	☐	☐	☐	☐	☐
7. Do you have difficulty watching a movie or videotape/disc because you become sleepy or tired?	☐	☐	☐	☐	☐
8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?	☐	☐	☐	☐	☐
9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?	☐	☐	☐	☐	☐
	(0) **I don't engage in sexual activity for other reasons**	(4) **No**	(3) **Yes, a little**	(2) **Yes, Moderately**	(1) **Yes, Extremely**
10. **Has your desire or intimacy for sex been affected because you are sleepy or tired?**					
Patient Name:	**DOB:**		Total Score:		

©Weaver, June, 2004 fosq. 97 updated 6/04 Functional Outcomes of Sleep Questionnaire (FOSQ) short

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PATIENT RIGHTS AND REQUIREMENTS

- A patient is treated with dignity, respect, and consideration;
- A patient is not subjected to Abuse, Neglect, Exploitation, Coercion, Manipulation, Sexual abuse, Sexual assault, restraint or seclusion (except as allowed by ARS R9-10-1012B, Retaliation for submitting a complaint to the Department of Health Services or another entity, misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student.
- A patient or patient's representative, except in an emergency, may either consent to or refuse treatment and may refuse or withdraw consent for treatment before treatment is initiated. Except in an emergency, a patient or a patient's representative is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic drug or surgical procedure.
- A patient or patient's representative is informed of the following;
  - The outpatient treatment centers policy on health care directives and the patient complaint process.
  - Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes.
  - Except as otherwise permitted by law, provides written consent to the release of information in the patient's Medical or Financial records.
- A patient has the following rights:
  - Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
  - To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
  - To receive privacy in treatment and care for personal needs.
  - To review upon written request, the patient's own medical record according to ARS 12-2293, 12-2294, and 12-2294.01.
  - To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient.
  - To participate or have the patient's representative participate in the development of, or decisions concerning treatment.
  - To participate or refuse to participate in research or experimental treatment.
  - To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights

SERVICES AND ACKNOWLEDGMENT OF CONSENT

I consent to Physician services included in any sleep consultation or follow up that may include but not limited to general physical examinations including ear, nose and throat; cardio/pulmonary, PAP Therapy trial and/or mask fitting, other therapy or services and gathering of general vitals. (Blood pressure, Height/Weight, neck circumference, etc.) By signing below I request that Valley Sleep Center/Physicians and its associates perform consultations and related services and sign this voluntarily to consent and authorize these procedures. I understand that if it is determined during any exam/consultation that my health requires urgent care beyond what the Sleep Center can provide, emergency services may be contacted for support. I have been given the opportunity to review and sign this consent form and I agree and understand this document.

ADVANCED DIRECTIVE

Healthcare Directives information is provided by the state of Arizona and has a system for patients to apply and store documents for healthcare provider access. Advance directives are documents that outline what healthcare and treatment decisions should be made if you are unable to communicate these wishes. Please visit https://healthcurrent.org/azhdr/ to learn more. There is no filing fee, and the process takes up to three weeks. A Healthcare Directive is not required for your visit.

Patient or Guardian Signature: **Date:** _____

Insomnia ISI

The Insomnia Severity Index has seven questions. 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
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

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

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

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

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

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

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

7. 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 (0) A Little (1) Somewhat (2) Much (3) Very Much Interfering (4)

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SNQ

Based on the previous week:

1. **Did you feel tired or fatigued during the day or evening?**

   NEVER RARELY SOMETIMES FREQUENTLY ALWAYS

2. **Were you sleepy or drowsy during the day or evening?**

   NEVER RARELY SOMETIMES FREQUENTLY ALWAYS

3. **Did you take any naps or fall asleep briefly during the day or evening?**

   NEVER RARELY SOMETIMES FREQUENTLY ALWAYS

4. **Did you feel you had been getting an adequate amount of sleep?**

   NEVER RARELY SOMETIMES FREQUENTLY ALWAYS

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and check the appropriate space.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. 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				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use a circle to indicate your answer)*	Not at all	Several days	More than 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 is 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