Valley Sleep Center
A Night and Day Difference!

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

INSOMNIA FOLLOW UP 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**
☐Acid Reflux or GERD
☐Arthritis
☐Cardiac Arrhythmias
☐Coronary Artery Disease
☐Diabetes Mellitus
☐Enuresis/Urinating in Sleep
☐Heart Attack
☐High Cholesterol
☐Insomnia
☐Kidney Disease
☐Narcolepsy
☐Obesity
☐Peripheral Neuropathy
☐Sciatica
☐Sleep Talking/Somnambulism
☐Teeth Grinding/Bruxism
☐Cancer - Type: _____

☐**No Medical History**
☐Allergies or Allergic Rhinitis
☐Asthma
☐Central Sleep Apnea
☐ COPD
☐ Eating Disorder
☐ Excessive Daytime Sleepiness
☐Heart Failure
☐Hypoxemia
☐Insufficient Sleep
☐Memory Loss
☐Nightmares
☐Obstructive Sleep Apnea
☐Post-Traumatic Stress Disorder
☐Seizures
☐Sinus Problems/Sinusitis
☐Thyroid Disorder/Type: _____

☐Anxiety
☐Bipolar Disorder
☐Chronic Pain
☐Depression
☐Enlarged Tonsils/Hypertrophy
☐Head Injury
☐HBP/Hypertension
☐Idiopathic Hypersomnia
☐Iron Deficiency
☐Myocardial Infarction/Heart Attack
☐Night Terrors or Night Arousals
☐Palpitations
☐Restless Legs Syndrome
☐Shift Work Disorder
☐Stroke or CVA

☐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:		

Functional Outcomes of Sleep Questionnaire (FOSQ) short

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)

CBT-I Sleep Diary - Track your Sleep Patterns

Instructions: Do your best to ESTIMATE your sleep patterns during the week by using the chart below to assist you. Do not worry about how accurate you are and do not spend your time looking at the clock during the night to be more accurate. Complete this form on the morning AFTER, reflecting back upon the night.

Date	Sleep medications you took:	Did you sleep at any time during the day (including dozing?)	Time you got into bed for the night?	What time did you try to fall asleep without the use of technology and lights?	Estimate how long it took to fall asleep:	Estimate how many times you woke during the night:	Estimate how much time you were awake during the night:	What was the final time you woke up?	What time did you get out of bed to start your day?	Estimate how much sleep you got during the night:	Rate how you felt during the daytime: Poor 1 – 10 Great		
											Morning	Afternoon	Evening
11/11/22	Zolpidem 10mg	None	11:00 PM	11:30 PM	2 Hours	5	2 Hours	7:00 AM	8:00 AM	4 Hours	2	3	8

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:** _____