RUTH H STEINMAN, MD

PATIENT INFORMATION

LEGAL Name____ Date of Birth__________________ Preferred

Name (if different from legal name) ____

Address____ City__________ State_____ Zip______ Mailing

Address_______________________________________ City__________ State _____ Zip_____

(If different) Phone: Primary ________________________________ Secondary _____________________________

(**Best place to reach you or leave a message**) Person responsible for your account

______________________________________ relationship_______

Relationship status: Single Married Partnered Name of Spouse/Partner (parents/guardian for

minor)____ Children & Ages (siblings for minor)

____

Name of referring physician ____ In case of emergency notify

___________________ Relationship___________Phone_________________

REFERRED BY - IF OTHER THAN YOUR DOCTOR____

Please explain why you are seeking help at this time:

Please explain how your problems are affecting your work and relationships, plus your general functioning:

Patient name___________________________________ Date of Birth_______________ Page 2

On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now:

Please check any health problems you have or have had:

_____lung _____high blood pressure _____arthritis _____liver _____diabetes _____other pain _____kidney _____seizures _____cancer _____stomach/intestinal _____head injury

Medicines you are allergic to:

Medicines you now take:

How much and what kind of exercise you get:

Height ________________ Weight ________________

SUBSTANCE USE Average amount Past 2 months Most ever used

Coffee ______________________ _________________ Cigarettes ______________________ _________________ Alcohol ______________________ _________________ Recreational Drugs ______________________ _________________

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

___Physical health ___ In-law problems ___Using drugs ___Chronic Pain ___ Job or school performance ___Panic Attacks ___ Low mood ___Friendships ___Phobias ___ Mood swings ___Financial problems ___ Anxiety symptoms ___ Energy/motivation level ___ Obsessions (unwanted thoughts) ___*sweating* ___ Memory ___ Nightmares ___ *short of breath* ___ Concentration ___ Thoughts of hurting someone ___ *stomach upset* ___ Sleep ___ Compulsions (unwanted actions) ___*dizziness* ___ Sexual functioning ___ Flashbacks ___ *choking* ___Suicidal thoughts ___ Paranoid thoughts ___ *racing heart* ___ Spirituality/religion ___ Domestic violence (verbal) ___ *weakness* ___ Marriage/relationship ___ Domestic violence (physical) ___*dry mouth* ___ Family conflicts ___ Drinking alcohol ___ *feeling trapped*

___ *panic*

For the following, please circle YES or NO and give details:

Have you had counseling or psychotherapy in the past? YES - NO ____________________________ Have you ever taken medication for your emotional or mental health? YES – NO ____________________ Have you ever been hospitalized for psychiatric problems? YES – NO _____________________________ Have you ever been arrested? YES – NO ____ Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES – NO

Have you ever had any experiences that you would consider traumatic or abusive? YES - NO

Have you ever tried to kill yourself or hurt yourself in any way? YES – NO ________________________ Is there any danger these days that you might hurt yourself or someone else? YES – NO ______________

Please describe your education:

Please describe the family you grew up in including your parents and names and ages of your siblings:

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:

Please describe your support system (family you are close to, friends you talk with, etc.):

What is your current job and how do you like it?

SLEEP QUESTIONAIRE –
PLEASE COMPLETE IF YOU HAVE A SLEEP PROBLEM

Name____ Date of Birth_________________

What is the main problem with your sleep? ____ Are you a shift worker? **YES** or **NO** If so, what hours do you work? ______________________________ On average, how many hours of sleep do you get in 24 hours? _________ All at once or with naps? ________________ Is this enough? **YES NO**

INSOMNIA - POOR SLEEP QUALITY

Or too much? **YES NO**

Do you have problems getting to sleep or staying asleep? **YES NO**

If so, is your main problem getting to sleep, or waking up too much, or both? _________________ Do you tend to sleep at the wrong time; that is, are you an extreme night owl or morning lark? **YES NO**

EXCESSIVE SLEEP OR SLEEPINESS

If so, what is your best window of time for sleeping? ____________________________________ Do you legs or arms itch, burn, tingle or just feel "fidgety" when you are trying to sleep? **YES NO**

Are you often too sleepy when you need to be awake? **YES NO**

On your usual schedule in recent weeks or months, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to answer according to how you think they might affect you. Choose the most appropriate number for each situation:
0 = would never doze 1 = slight chance of dozing 2 = moderate chance 3 = high chance of dozing

Sitting & reading 0 1 2 3 WatchingTV 0 1 2 3 Sitting in a public place, like a waiting room 0 1 2 3 The Epworth Sleepiness Scale Riding in a car for 1 hour 0 1 2 3 (John, M.W. (1993) Chest 103:30-36) Lying down torest 0 1 2 3 Sitting & talking 0 1 2 3 Sitting after lunch without alcohol 0 1 2 3 Driving a care while stopped in traffic 0 1 2 3

Total Score _________

If your score is 10 or higher, a sleep disorders consultation is recommended.

Other situations in which you fall asleep when you don't mean to? _________________________________

Do you snore? **YES NO** Loudly enough to disturb others? **YES NO** Stop Breathing? **YES NO**

Do your legs or arms twitch or jerk during sleep? **YES NO** Whole body? **YES NO**

SLEEP BEHAVIORS and OTHER PROBLEMS

If either, do these twitches or jerks seem to interfere with your sleep? **YES NO**

Do you sleepwalk or act out dreams: **YES NO**

Do you fall out of bed or have unusual movements during sleep? **YES NO**

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MOOD DISORDER QUESTIONAIRE

Patient Name ________________________________ Date of Birth ______________

1. Has there ever been a period of time when you were not your usual self and

…………………………………………………………………………………………………

You felt so good or so hyper that other people though you were not your normal self
or you were so hyper that you got into trouble?

○yes

○no You were so irritable that you shouted at people or started fights
○yes
○no or arguments?
○yes
○no

You felt much more self confident than usual?

○yes
○no

You got much less sleep than usual and found you didn't miss it? You

were much more talkative or spoke much faster than usual?

○yes

○no Thoughts raced through your head or you couldn't slow down
○yes

no your mind? You were so easily distracted by things around you that you had trouble

○yes
○no

concentrating or staying on track? You had much

more energy than usual?

○yes

○no You were much more active or did many things more than usual?
○yes
○no You were much more social or outgoing than usual, for example,
○yes
○no

you telephoned friends in the middle of the night?

○yes
○no

You were much more interested in sex than usual? You did things that were unusual for you or that other people might

○yes

○no have thought were excessive, foolish, or risky?

Spending money got you or your family into trouble?

○yes

○no ....

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

○yes

○no

3. How much of a problem did any of these cause you – like being able to work; having family, money or legal troubles, getting into arguments or fights?

○No Problem

○Minor Problem

○ Moderate Problem

○ Serious Problem