**How to fill out this form**

* Use your TAB key to go from one entry box to the next.
* Most response boxes have an automatic entry. You may 1) leave this as it is and tab forward, or 2) select from the drop-down list OR type over the entry, depending on the type of box.
* **If you elect to not answer a question you may do so.** Please enter XXXX in the box or write a comment at the end of the section so I will know the question has not been answered.
* **The assessment should take about 20 - 40 minutes to complete.**
* Please remember to save the document periodically as you fill it in so you minimize the risk of losing what information you have already entered.

 **Date: .**

 **Your legal name:**

 Do you prefer to be called by another name? If so, what?

 **Date of Birth:** **Age:** **Gender:** **[ ]** Male **[ ]** Female **[ ]** Transgender

 Referral Source: Referral contact number, if known:

 Occupation:

Is there any kind of deadline/time constraint regarding your dealing with this situation?

None

Is there any major life event or situation coming up for you to deal with in the next few months?

None

If you decide to get help for this, is there anyone else who will be involved in this besides you?

None

**1. LET’S LOOK AT YOUR SLEEP**

Do you have difficulty

[ ]  Falling asleep

[ ]  Staying asleep

[ ]  Waking up after sleeping

[ ]  Feeling refreshed after sleeping

[ ]  Staying awake during the day

On average, how many hours of sleep a night have you been getting this month?

Is this a change?

When you sleep do any of the following occur?

[ ]  recurring images [ ]  recurring dreams [ ]  nightmares

[ ]  startled awakenings [ ]  night sweats

Comments: None.

CRITERIA FOR CHRONIC INSOMNIA:

**Have you had insomnia an average of at least three times a week over at least the last three months?**

If so, how often is usual? [ ]  2-3 times a week [ ]  3-4 times [ ]  4-6 times [ ]  5-7 times

If so, how long has this been going on? [ ]  3 months [ ]  4-6 months [ ]  6-12 months [ ]  more than a year

**Do you feel that your insomnia is having a significant negative impact on your functioning during the day? .**

Please rate your **how much impact you think the insomnia is having** **right now for you** on the scale below:

 Not much Some A moderate amount Quite a bit A lot A huge impact

**[ ]  1 [ ]** 1.5 **[ ]  2 [ ]** 2.5 **[ ]  3 [ ]** 3.5 **[ ]  4 [ ]** 4.5 **[ ]  5 [ ]** 5.5 **[ ]  6 [ ]** 6.5  **[ ]  7 [ ]** 7.5  **[ ]  8 [ ]** 8.5 **[ ]  9 [ ]** 9.5  **[ ]  10**

**Do you feel you are having difficulty with any of the following:**

(these are some of the most common complaints for those with chronic insomnia)

 **[ ]** Irritability If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Sudden shifts in mood If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Overly intense moods If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Depression If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Easily frustrated or annoyed If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Anxiety If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

**[ ]** Difficulty remembering things If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** recent things **[ ]** things from the past

**[ ]** Difficulty thinking/concentrating If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Difficulty making decisions If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Difficulty with being too impulsive If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

**[ ]** Loss of interest in things or activities you used to enjoy If yes, from 1 to 10, how bad? N/A

 **[ ]** Loss of motivation If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Angry outbursts If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Moments of panic If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Feelings of losing control If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Self-anger If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Guilt If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Shame If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Feeling exhausted but unable to relax If yes, from 1 to 10, how bad? N/A

**Are you having problems with any of these unusual ways of thinking?**

 **[ ]** Racing thoughts If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Ruminating – going over & over things If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Difficulty staying focused/thoughts going off on tangents If yes, from 1-10, how bad is this? N/A

 **[ ]** Having intrusive thoughts If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Having intrusive images If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Feeling like you are obsessing about something If yes, from 1-10, how bad is this? N/A

 **[ ]** Feeling a little paranoid If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Getting into some compulsive patterns If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Feeling like things are a little unreal If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Feeling disconnected from yourself If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

**What about your use of sleep medications and remedies?**

Prescription sleep medications **[ ]** Currently take **[ ]** Take occasionally **[ ]** Taken in the past **[ ]** Never used

Over the counter sleep meds **[ ]** Currently take **[ ]** Take occasionally **[ ]** Taken in the past **[ ]** Never used

Herbal sleep remedies **[ ]** Currently take **[ ]** Take occasionally **[ ]** Taken in the past **[ ]** Never used

Please rate your **how much stress in general you feel about your sleep problem(s)** on the scale below:

 Very Low Low Average/Moderate Moderately High Very High Extreme

**[ ]  1 [ ]** 1.5 **[ ]  2 [ ]** 2.5 **[ ]  3 [ ]** 3.5 **[ ]  4 [ ]** 4.5 **[ ]  5 [ ]** 5.5 **[ ]  6 [ ]** 6.5  **[ ]  7 [ ]** 7.5  **[ ]  8 [ ]** 8.5 **[ ]  9 [ ]** 9.5  **[ ]  10**

**Are you familiar with any of these common non-drug interventions for better sleep?**

Sleep hygiene **[ ]** Currently use **[ ]** Have tried **[ ]** Know about but haven’t tried **[ ]** Never used

Relaxation techniques **[ ]** Currently use **[ ]** Have tried **[ ]** Know about, haven’t tried for sleep **[ ]** Never used

Yoga **[ ]** Currently use **[ ]** Have tried **[ ]** Know about, haven’t tried for sleep **[ ]** Never used

Acupuncture **[ ]** Currently use **[ ]** Have tried **[ ]** Know about, haven’t tried for sleep **[ ]** Never used

Meditation **[ ]** Currently use **[ ]** Have tried **[ ]** Know about, haven’t tried for sleep **[ ]** Never used

### 2. LET’S SEE IF YOU MAY HAVE A SLEEP PROBLEM OTHER THAN CHRONIC INSOMNIA

**Do you have this kind of sleep schedule?**

 **[ ]** You are not a shift-worker

 AND

 **[ ]** You have trouble falling asleep at a “normal” time (for example, 10 PM or midnight) and trouble waking up

 at a “normal” time (for example, 6 or 8 AM). You are a “night owl.”

 OR

 **[ ]** You have trouble staying awake until a “normal” bedtime and trouble staying asleep until a “normal”

 wake-up time. You are an “early bird” or “morning person.”

 AND

 **[ ]** The difference in your schedule is more than 2 hours away from “normal.”

 AND

 **[ ]** When you are allowed to sleep on your own schedule you sleep just fine and wake up refreshed.

 AND

 **[ ]** This “natural” sleep schedule of yours does not significantly change from summer to winter.

**If you checked a box for each question you may have a circadian rhythm disorder. I will contact you to discuss this.**

**Do you have these sleep symptoms?**

 **[ ]** You snore many nights loud enough to be heard through a closed door or as loud as a normal conversation

 AND/OR

 **[ ]** You choke or gasp while sleeping

 AND/OR

 **[ ]** You pause in your breathing while sleeping

 AND/OR

 **[ ]** You sleep what should be an adequate number of hours but wake up feeling sluggish or unrefreshed

 AND

 **[ ]** you have morning headaches or dry mouth upon awakening

 AND/OR

 **[ ]** you are significantly overweight and/or have hypertension

 AND

 **[ ]** You feel sleepy during the day

 AND/OR

 **[ ]** You have difficulty during the day staying awake when doing routine or monotonous activities

**If you checked a box for each question you may have obstructive sleep apnea. I will contact you to discuss this.**

**Do you have these sleep symptoms?**

 **[ ]** You have strong urges to move your legs

 AND

 **[ ]** You experience this most when you are resting or laying down

 AND

 **[ ]** The urge goes away temporarily when you do move your legs

 AND

 **[ ]** This leg movement interferes with you falling asleep or going back to sleep if you awaken at night.

**If you checked all 4 boxes you may have Restless Leg Syndrome. I will contact you to discuss this.**

**Do you have these sleep symptoms?**

 **[ ]** You have recurring dreams that have these characteristics:

1. They have an involved or elaborate story or narrative
2. They cause you to have very strong negative feelings (fear, disgust, anger, etc.)
3. When you are awakened you are not confused as to whether the dream was real or imaginary

 AND

 **[ ]** These dreams happen towards the end of your sleeping, not towards when you first go to sleep

 AND

 **[ ]** When you wake up you aren’t confused as to whether the dream was real or imaginary

 AND

 **[ ]** After you wake up the dream continues to bother you and/or has a significant impact on your daytime

 functioning.

**If you checked all 4 boxes you may have Nightmare Disorder. I will contact you to discuss this.**

**Have you had any of the following sleep symptoms?**

 **[ ]** Talking in your in your sleep, more than once in the last three months

 OR

 **[ ]** Sleepwalking, more than once in the last two years

 OR

**[ ]** Engaging in some other activity while asleep that normally you would do when awake (eating, driving a car, sex, etc.), at least once in the last 20 years

**If you checked any of these boxes you may have a parasomnia disorder. I will contact you to discuss this.**

***NOTE: If you do meet the screening criteria above, don’t panic. These questions only indicate a possibility of having one of these disorders. Also, all the above disorders are treatable. They simply require a health intervention different than the CBT for chronic insomnia.***

### 3. LET’S EXPLORE SOME OTHER THINGS THAT MAY BE AFFECTING YOUR INSOMNIA

**GENERAL HEALTH**

How is your current health?

Do you have any chronic medical conditions? No OR **[ ]** I prefer to provide this information verbally.

Do you have any chronic pain? No. OR **[ ]** I prefer to provide this information verbally.

If so, please rate you’re your **average level of chronic pain** on the scale below:

 Very Low Low Average/Moderate Moderately High Very High Extreme

**[ ]  1 [ ]** 1.5 **[ ]  2 [ ]** 2.5 **[ ]  3 [ ]** 3.5 **[ ]  4 [ ]** 4.5 **[ ]  5 [ ]** 5.5 **[ ]  6 [ ]** 6.5  **[ ]  7 [ ]** 7.5  **[ ]  8 [ ]** 8.5 **[ ]  9 [ ]** 9.5  **[ ]  10**

Do you have any current non-chronic medical conditions? No OR **[ ]** I prefer to provide this information verbally.

**OTHER THAN FOR SLEEP:**

Are you taking any prescription medications? (if yes, identify what, purpose of taking it, and for how long) No.

 Details: N/A

 Are you routinely taking any non-prescription (over the counter) medications other than vitamins? No.

 Details: N/A

 Are you routinely taking any dietary supplements or herbal remedies? No.

 Details: N/A

Is there anything else that you currently do that is done specifically to deal with an illness or injury (but not sleep), such as ritual healing, a special diet, physical therapy, yoga, meditation or acupuncture? No.

If yes, what? N/A

Do you have any physical or medical conditions which might interfere with behavioral health treatment or which require any special considerations from us? (describe) No.

Do you have any medication or environmental allergies: No.

Have you been having any difficulties recently with any of your senses (sight, smell, touch, taste, or hearing)? No.

**Do you have frequent or unexplained:**

[ ]  headaches, [ ]  dizziness, [ ]  fatigue, [ ]  nausea, [ ]  constipation, [ ]  diarrhea, [ ]  tremors, or

[ ]  any other physical symptoms you consider unusual or for which you have concerns?

If any above were checked yes, how are you treating these? N/A

OR check here: [ ]  I prefer to provide this information verbally.

**For women:** **Are you currently pregnant?** No. If yes, when is your due date? N/A

**Have you** **significantly changed anything physically** in the last two months (changed your eating pattern, exercise, or sleep schedule; stopped drinking, smoking or taking a medication; started a new diet; etc.)? No.

If yes, what? N/A

Has anything physical significantly changed **for you** in the last two months (injury, menopause, etc.)? No.

If yes, what? N/A

When did you last have a complete physical exam?

**EATING**

Are you having any difficulty with your eating or diet?

If yes, what? N/A

What’s your eating been like the last two weeks (when, what, how much)? Normal pattern, varied diet.

Is this a change?

Comments: None.

Have you lost or gained more than 10 pounds in the past 6 months: If yes, explain: N/A

**USE of BIOLOGIC AGENTS**

Do you drink more than 10 ounces of caffeinated beverages or have more than 2 energy drinks a day?

Do you drink caffeinated beverages or energy drinks after 2 PM?

Do you have a “sweet tooth” and/or consume high sugar treats or snacks regularly?

If so, do you do this in the hours just before bedtime?

Do you use tobacco?

If yes, describe use: N/A Aware of risks? N/A

Do you use alcohol?

If yes, describe use: N/A Aware of risks? N/A

Do you use marijuana?

If yes, describe use: N/A Aware of risks? N/A

**BREATHING**

Do you have any difficulty regarding breathing?

If so, what and when? N/A

Comments: None.

**EXERCISE**

Do you engage in any regular exercise Not really.

If so, what? N/A

How often? N/A

At what time(s) of day? N/A

Do you have any limitations that prevent you from exercising or that limit your ability to exercise?

If so, what? N/A

**If you have any additional comments regarding your exercise please enter them here:** None.

**OTHER PHYSiCAL**

Is there **anything else going on for you physically** that you have concerns about, think is unusual, or wonder if it is affecting your sleep?

If yes, describe: N/A

**If you have any additional comments regarding your physical health please enter them here:**

None.

**HOME**

Is anyone else in the place you’re living right now having **disruptive** sleeping,substance use, and/or physical or mental health issues?

If yes, do you think these issues play a part in your own sleep issues?

If so, how? N/A

Do you feel physically and emotionally safe where you are living? Yes.

Are there any other major concerns, issues or problems going on right now where you’re living (construction, tree pollen, partying neighbors, etc.)?No.

If yes, describe: None.

**If you have any additional comments regarding your home situation please enter them here:**

None.

**CURRENT RELATIONSHIPS**

**How are your relationships doing?** – Are you having any significant relationshipstresses or concerns at this time with your primary relationship (partner, spouse, parent, etc.)? No.

Do you think your current relationships are **being affected by** your sleep issues?

Comments: None.

Do you think your current relationships are **affecting** your sleep issues?

Comments: None.

Are your sleep difficulties affecting you’re the physical or psychological intimacy in your relationship(s)?

Comments: None.

Do you feel you have a good support system of people who can help you through things?

**If you have any additional comments regarding your relationships please enter them here:**

None.

**STRESS**

Please rate your **current level of total stress** **in your life** by checking a box on the scale below:

 Very Low Low Average/Moderate Moderately High Very High Extreme

**[ ]  1 [ ]** 1.5 **[ ]  2 [ ]** 2.5 **[ ]  3 [ ]** 3.5 **[ ]  4 [ ]** 4.5 **[ ]  5 [ ]** 5.5 **[ ]  6 [ ]** 6.5  **[ ]  7 [ ]** 7.5  **[ ]  8 [ ]** 8.5 **[ ]  9 [ ]** 9.5  **[ ]  10**

Are you having **high or unusual stress** with any of the following:

 **[ ]** Finances If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Job/work/occupation/school If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Family/extended family/home life If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Friends If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Spirituality If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

**[ ]** Logistics/transportation If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Health of yourself If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Health of a loved one If yes, on a scale of 1 (low) to 10 (high), how bad is this? N/A

 **[ ]** Other (identify in comment section below) If yes, on a scale of 1-10 (high), how bad is this? N/A

**If you have any additional comments regarding stress please enter them here:**

None.

**MENTAL HEALTH**

Are you currently diagnosed with any mental health condition? OR **[ ]** I prefer to provide this information verbally.

 If yes, please describe: N/A

If yes, is this condition currently being treated and under control or in remission? N/A

Is there anything you feel it would be helpful to know regarding your current mental health or psychological history that you believe might be affecting your sleep?

 If yes, please describe: N/A OR CHECK HERE: **[ ]** I prefer to provide this information verbally.

**If you have any additional comments regarding your psychological health please enter them here:**

None.

*Thank you. That completes this assessment.*

**What to do now with this assessment**

1) Save the document

2) Send the assessment in. You may:

 1) email the document to uncommon.alaska@gmail.com OR

 2) print out a copy and send it to P.O. Box 71162 Fairbanks AK 99707 OR

 3) bring a flashdrive with the document on it to the first session.

NOTE: If you choose the last option I will not have time to review the assessment before the first session. In this case, please contact me before that session if one or both of the following is true:

1. you do not meet the diagnostic criteria for chronic insomnia (insomnia 3 or more times a week for at least the last three months and which affects you when you’re awake)
2. you meet the screening criteria for one or more of the other sleep disorders of section 2.

***Thanks!***