National Jewish Health
Science Transforming Life

Name: ________________________________ Date of Birth: _______________ Today's Date: __________

Current Medical/Mental Health Conditions and Medications

Medical/Mental Health Condition	Medication/Treatment	Dose and Duration of Treatment

List All Past Medical Conditions

List All Past Surgeries and Hospitalizations	Date

Main Complaint: (Please describe what brings you to the sleep clinic)

____

____

How long have you had this problem? ____________________________

Have you ever seen a healthcare provider for this problem? ___ Y ___ N

Have you ever had a sleep study? ___ Y ___ N

If yes, where and when? ____

Are you currently diagnosed with any sleep disorder(s)? ___Y ___N

If yes, please list the diagnoses and describe any current treatments: ___________________________________

____

What is your normal bedtime? __________ a.m./p.m.

On average, how long does it usually take you to fall asleep? ____________

On average, how many times do you wake up during the night? __________

On average, how much sleep do you lose from being awake during the middle or end of the night? ________________

What time do you normally wake up for the day? __________________

What time do you normally get out of bed for the day? ______________

On average, how much total sleep do you think you get each night? ______________

How many days per week do you nap? ________ When you nap, how long do you nap? ________

Do you work different shifts? ___ Y ___ N If yes, what shifts do you work? _____________________________________

How many times per week do you exercise? ______ What time do you usually exercise? ______ a.m./p.m.

Please describe your bedtime routine: ____

____

What do you do when you can't sleep? ____

____

Have any of your family members been afflicted with a sleep disorder? ___ Y ___ N If yes, please describe:

____

How many caffeinated drinks do you have per day? ______ What is the latest time you will have caffeine? ______

How many days per week do you drink alcohol? ______ When you drink, how many drinks do you have? ______

Do you smoke or chew tobacco? ___Y ___N If yes, how much do you smoke/chew per day? ______

Do you use marijuana? ___Y ___N If yes, how much do you use per day/week? ______

Do you use other recreational drugs? ___Y ___N If yes, how much do you use per day/week? ______

Have you ever had legal, work, or family problems because of alcohol or drug use? If yes, describe: _________________
____

Please answer the following questions using the following scale (consult bed partner as needed):

0=Never 1=Rarely 2=Sometimes 3=Often 4=Frequent 5=Always

0 1 2 3 4 5……………………I sometimes fall asleep at inappropriate times

0 1 2 3 4 5……………………I fall asleep at work/school

0 1 2 3 4 5……………………I fall asleep at meetings

0 1 2 3 4 5……………………I have problems with performance at work/school because of fatigue/tiredness

0 1 2 3 4 5……………………I do not feel refreshed when I awaken

0 1 2 3 4 5……………………I have to take naps during the day

0 1 2 3 4 5……………………I have been told I snore

0 1 2 3 4 5……………………Others cannot sleep in the same room because I snore

0 1 2 3 4 5……………………I have been told that I stop breathing while asleep

0 1 2 3 4 5……………………I awaken with headaches

0 1 2 3 4 5……………………I sweat at night

0 1 2 3 4 5……………………I have awakened during the night choking

0 1 2 3 4 5……………………I have trouble falling asleep at night

0 1 2 3 4 5……………………I have trouble staying asleep at night

Please answer the following questions using the following scale (consult bed partner as needed):

0=Never 1=Rarely 2=Sometimes 3=Often 4=Frequent 5=Always

0 1 2 3 4 5……………………I awaken in the morning long before I want to

0 1 2 3 4 5……………………I have been told that I kick at night

0 1 2 3 4 5……………………I have aching or crawling sensations in my legs

0 1 2 3 4 5……………………I experience leg discomfort during the night

0 1 2 3 4 5……………………I cannot keep my legs still at night

0 1 2 3 4 5……………………I have been told I walk in my sleep

0 1 2 3 4 5……………………When I laugh or get angry, I feel like going limp

0 1 2 3 4 5……………………I awaken during the night with heartburn

0 1 2 3 4 5……………………I have been told that I act out my dreams

Epworth Sleepiness Scale:

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:
0 = would *never* doze or sleep
1 = *slight* chance of dozing or sleeping
2 = *moderate* change of dozing or sleeping
3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total Score (add the scores up)	
This is your Epworth Score	_____

Adapted from Johns, M. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. *Sleep*, 14, 540-545

The Insomnia Severity Index

Please rate the current (i.e., last two weeks) severity of your insomnia problem(s).

	None	*Mild*	*Moderate*	*Severe*	*Very Severe*
Difficulty falling asleep:	0	1	2	3	4
Difficulty staying asleep:	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
0	1	2	3	4

To what extent do you consider your sleep problem to interfere with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)

Not at all interfering	A little	Somewhat	Much	Very much interfering
0	1	2	3	4

How noticeable to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all noticeable	A little	Somewhat	Much	Very much noticeable
0	1	2	3	4

How worried/distressed are you about your current sleep problem?

Not at all worried	A little	Somewhat	Much	Very much worried
0	1	2	3	4

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Flinders Fatigue Scale

We are interested in the extent that you have felt fatigued (tired, weary, exhausted) over the last two weeks. We do not mean feelings of sleepiness (the likelihood of falling asleep). Please circle the appropriate response in accordance with your average feelings over this two-week period.

Name: ____ Date: ____________

1. Was fatigue a problem for you?

☐	☐	☐	☐	☐
Not at all		Moderately		Extremely

2. Did fatigue cause problems with your everyday functioning (e.g., work, social, family)?

☐	☐	☐	☐	☐
Not at all		Moderately		Extremely

3. Did fatigue cause you distress?

☐	☐	☐	☐	☐
Not at all		Moderately		Extremely

4. How often did you suffer from fatigue?

☐	☐	☐	☐	☐
0 days/week	1-2 days/week	3-4 days/week	5-6 days/week	7 days/week

5. At what time(s) of the day did you typically experience fatigue? (Please tick box(es))

Early Morning	☐	Late Afternoon	☐
Mid Morning	☐	Early Evening	☐
Midday	☐	Late Evening	☐
Early Afternoon	☐		

6. How severe was the fatigue you experienced?

☐	☐	☐	☐	☐
Not at all		Moderately		Extreme

7. How much was your fatigue caused by poor sleep?

☐	☐	☐	☐	☐
Not at all		Moderately		Entirely

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Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3, which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:
0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Disclosure Statement

This document provides important information about your provider, your rights as a client, and other aspects of your care at this clinic. Please read it carefully.

Clinician:	**Education:**
Robert N. Glidewell, PsyD National Jewish Health 499 E. Hampden Ave., Suite 300 Englewood CO 80113	Doctor of Psychology Certified, Behavioral Sleep Medicine Specialist Post-Doctoral Fellowship in Behavioral Sleep Medicine Bachelor of Science, Psychology

Degrees and Certifications	**Associated Education, Experience, and Training**
Licensed Clinical Psychologist	Completion of a doctoral degree in clinical psychology or related field and at least 1000 hours of supervised post-doctoral clinical experience.
Doctor of Psychology	A minimum of three years of graduate course work, completion of a doctoral dissertation, and completion of at least 2200 hours of supervised pre-doctoral clinical experience.
Certified, Behavioral Sleep Medicine Specialist	Completion of a doctoral degree in a health-related field, possession of a currently active state issued license to provide health-related clinical services, and at least 1000 hours of supervised post-doctoral clinical experience in behavioral medicine or behavioral sleep medicine.
Post-Doctoral Fellowship in Behavioral Sleep Medicine	12 months of post-doctoral didactic training and supervised experience in the laboratory assessment, scientific research, and clinical evaluation and treatment of sleep and sleep disorders.
Bachelor of Science, Psychology	Four years of undergraduate course work

Information for Clients

When you come for treatment, you are buying a service. Good information will help you make a good decision. Below are some things you should know.

I am a licensed clinical psychologist in the state of Colorado and a Certified Behavioral Sleep Medicine Specialist. I received my Bachelor of Science in Psychology from Regis University in 2000 and my Doctor of Psychology from the Colorado School of Professional Psychology in 2006. I have completed advanced post-doctoral training in sleep disorders and behavioral sleep medicine. In addition, I am a member of the American Academy of Sleep Medicine.

The Mental Health Section of the Colorado Division of Registrations has the general responsibility of regulating the practice of licensed psychologists. The Board of Psychologist Examiners can be reached at, 1560 Broadway, Suite 1350, Denver, Colorado 80202, 303-894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker,

Information for Clients (Cont.)

Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

Client Rights

As a client you are entitled to receive information about the methods of treatment, the techniques and the approximate duration of treatment (if known), and the fee structure. Much of this information is provided within this disclosure statement. Speak to your clinician if you have questions or would like to receive additional information.

You may seek a second opinion from another clinician or stop treatment at any time.

In a professional relationship, sexual intimacy between a clinician and a client is never appropriate. Any violation should be reported to the Board of Psychologist Examiners.

Confidentiality

The information provided by a client during treatment sessions or gained by testing is legally confidential. There are exceptions to the general rule of legal confidentiality. Some of these exceptions are listed in the Colorado Statues (see section 12-43-218. C.R.S., in particular) and the Notice of Privacy Practices you were provided. You should be aware that legal confidentiality does not apply in criminal or delinquency proceedings or in the case of a grievance board inquiry regarding services provided (see section 13-90-107 C.R.S.). There are other exceptions.

Exceptions

The following are a few examples of exceptions to the preceding written guidelines on confidentiality and must be reported.

If I suspect child abuse.
If I believe you are a danger to yourself or others.
You become unable to take care of yourself and additional help is required.

Duration of Treatment

Cognitive Behavior Therapy (CBT) is generally of short duration and is often completed in three to sixteen weeks. However, the effectiveness and progress of treatment are determined by many factors that are often difficult to estimate. Ask your clinician about the estimated treatment duration for you.

Methods and Techniques of Treatment

The primary method of treatment is Cognitive-Behavior Therapy (CBT).

Cognitive-Behavior Therapy is collaborative, structured, present-focused, and goal oriented. This means:

- You are considered an active participant in the design and implementation of all treatment activities
- Treatment activities proceed from a clear plan generated by the clinician and patient
- Treatment activities focus on changing current thoughts, behaviors, and emotions
- Treatment goals are chosen by clinician and patient; progress toward goals is routinely monitored

Cognitive-Behavior Therapy has two general goals:

- Eliminate problem behaviors and learn more effective behavior patterns
- Eliminate self-defeating thinking patterns and beliefs and learn more effective thought processes

Cognitive-Behavior Therapy techniques include: relaxation methods, desensitization, flooding, skills training, self-monitoring, self-management, modeling, role-playing, behavioral experiments, hypothesis testing, homework assignments, challenging cognitive distortions, scaling, and others

Fee Structure

All fees are charged and collected according to the policies of National Jewish Health.

Urgent and Emergency Care

Dr. Glidewell does not provide urgent or emergency care for patients in acute psychiatric distress. If you have severe and or persistent mental illness, you should seek the care of a psychiatrist, psychotherapist, or your primary care physician for these conditions. We will be happy to provide contact information for local providers upon request.

If, at any time during your treatment at this clinic, you become suicidal or have need for urgent or emergent psychiatric care please go to the nearest urgent care center, hospital emergency room, or contact the local crisis line (844-493-8255).

Electronic and Social Media

This section is written to help you understand how I conduct myself using electronic and social media as a mental health professional and how you can expect me to respond to various interactions that may occur between us through these media.
In an attempt to provide education to the general public I maintain websites, Facebook, Twitter, and other social and electronic media sites related to my clinical practice and other business activities. You may interact with these various pages/sites in the same manner as any other member of the general public. However, it is important to know that in order to respect and protect your privacy and confidentiality; I will never acknowledge a personal relationship with you or interact with you regarding personal or clinical matters through electronic or social media. It is also important to understand that the Information I communicate through these sites is intended for the general public and the information or advice provided to you as a patient may be different because it is tailored specifically to your particular situation and concerns.

If you need to communicate with me between sessions, please do so by calling the clinic. I or my office staff may communicate with you via e-mail or text regarding appointments, educational resources, self-help resources, and other administrative matters with your permission. I will communicate with you through email about your clinical care only if the communication is initiated by you. However, I do not recommend communication through email regarding any aspect of clinical care because **Email is <u>not</u> a secure or private form of communication.** If you initiate communication with me through email, you do so with the understanding that anything we discuss is neither private nor secure. I do not communicate with patients through text messages. I do not regularly monitor individual communications through my electronic and social media sites. Accordingly, it is unlikely that I will receive any personal communication and will not respond to personal communications from patients through these sites. **Please understand that these policies are designed to respect and protect your confidentiality and privacy as a patient of the clinic.**

You may find my practice and other business activities listed on Healthgrades, Psychology Today, and other business listing sites. My listing is not a request for testimonial, rating, or endorsement from you as a patient of the clinic. If you have comments regarding my practice or other business activities, I encourage you to bring these up with me or my staff directly.

Please know that any communication through e-mail with the clinic becomes part of your healthcare record. Finally, **please take your own confidentiality and privacy seriously and use social and electronic media with caution and awareness of who may have access to your activity and communications.**

Questions

Some openness is vital to successful assessment and treatment. You are encouraged to discuss these policies with your clinician. In addition, whenever you have questions or concerns about any aspect of your treatment, please discuss them with your clinician.

By signing this document you acknowledge that you have read, understood and accept these policies. Your signature below also acknowledges you have also received this information verbally.

DO <u>NOT</u> SIGN THIS FORM UNTIL YOU HAVE REVIEWED IT WITH YOUR PROVIDER

____ ___________________________________

Patient/Representative or Guardian Signature Date