Name: _____ Date: _____

CBT for Insomnia (CBT-1) Intake Form

PRESENTING PROBLEM & HISTORY

1. On average, how many <u>total hours</u> of sleep do you get per night? _____ (hours per night)
2. What is most upsetting about your current sleep? *(Check all that apply)*

   ☐ Difficulty falling asleep ☐ Waking up too early
   ☐ Difficulty staying asleep ☐ Difficulty waking up when you want
   ☐ Nightmares. How often do they occur? _____
   ☐ Daytime sleep attacks. How often do they occur? _____
   ☐ Other unusual nighttime behaviors (ie., sleep walking, acting out dreams, sleep eating, etc.) *WHICH ones?*
   If yes, which ones? _____

3. When did your sleep problems start & what set them off (ie., new baby, night shift work, illness, deployment, etc.)?

   _____

4. Have you ever participated in a sleep study? ☐Yes ☐No

   If yes, when and where? _____

5. Have you ever been diagnosed with sleep apnea? ☐Yes ☐No

   If yes, do you have a treatment device (ie., CPAP)? ☐Yes ☐No
   If yes, how regularly do you use it? _____ times per week (ie. Nightly would be 7)
6. Does anyone in your family have sleep problems? ☐Yes ☐No

   If yes, what kind? _____

SLEEP HABITS

On a typical week, estimate your sleep habits below: Weekday | Weekend

1. What time do you get into bed? (ie. 10:00 pm) _____ _____
2. What time do you turn your lights out? (ie. 10:30 pm) _____ _____
3. How long does it take you to fall asleep after lights out? (ie. 60 minutes) _____ _____
4. How many times do you wake up through the night? (ie. 2 times) _____ _____
5. How long are you awake in the middle of the night if you total up all the times you wake up? (ie. 30 minutes)
   _____ _____
6. What time do you wake up in the morning? (ie., 5:00 am) _____ _____
7. What time do you get out of bed for the day? (ie., 7:00 am) _____ _____
8. Do you have a bedtime routine? ☐Yes ☐No

   If yes, please describe it: _____
9. Are you taking any medications for sleep? (ie., Ambien, Tylenol PM, Benadryl, etc.) ☐Yes ☐No

   If yes, what kind?_____

   If yes, do you find them helpful? ☐Yes ☐No ☐Previously yes, but not anymore

10. Before going to bed & throughout the night, check any symptoms or behaviors that apply:

☐ Racing thoughts ☐ Watching the clock ☐ Worry ☐ Tension in the body ☐ Fear

☐ Eating in bed ☐ Using phone/tablet/computer in bed ☐ Watching TV in bed

☐ Lying in bed awake for long periods ☐ Using alcohol *or other substances* to help sleep

☐ Sleeping with pets in bedroom ☐ Sleeping outside of bedroom (chair, couch, etc.)

11. What do you do when you cannot sleep? _____
12. Do you nap or doze during the daytime? ☐ Yes ☐ No

If yes, how often? ☐ Every day ☐ A few times a week ☐ Vary rarely/Almost never

If yes, What time of day? ☐ Morning ☐ Afternoon ☐ Early Evening ☐ Before Bed

If yes, how long are your naps on average? _____

DAYTIME EFFECTS

How does sleep impact your daily routine or mood?

Low energy or fatigue: ☐ Most Days ☐ Some Days ☐ Never

Difficulty concentrating or focusing: ☐ Most Days ☐ Some Days ☐ Never

Impaired performance at work: ☐ Most Days ☐ Some Days ☐ Never

Impaired performance at home: ☐ Most Days ☐ Some Days ☐ Never

Any other effects of poor sleep? _____

DAILY HABITS/HEALTH BEHAVIORS

1. In the past months, have you used any of the following substances?

Substance Used	Yes/No	*If yes,* how many servings per day/week:
Caffeine *(coffee, tea, soda, energy drinks)*	No	
Tobacco (*cigarettes, cigars, smokeless tobacco/dip, e-cigarettes, vape)*	No	
Cannabis *(marijuana, CBD, THC, vape, etc.)*	No	
Alcohol *(beer, liquor, wine)*	No	
Illicit Drugs *(prescription drug misuse, cocaine, amphetamines, etc.)*	No	

2. How active are you during the day? *Check the best response:*

   ☐Very Active ☐Moderate Activity ☐Limited Activity ☐Mostly Sitting

3. What is your typical day time mood? Check the best response

   ☐Irritable/Grumpy ☐Depressed ☐Anxious/Worried ☐ Happy ☐ Other:_____

MEDICAL & PSYCHOLOGICAL COMORBIDITIES

1. What are other medical conditions are you managing? _____
2. Have you ever had a seizure? ☐Yes ☐ No

If yes, when? _____

3. What mental health conditions are you managing? (e.g., depression, anxiety, panic, PTSD, etc.)

_____

4. Have you ever been diagnosed with bipolar disorder? ☐Yes ☐No
5. What medications are you taking? *PLEASE INDICATE any that cause you to feel drowsy.*

_____ _____ _____

_____ _____ _____

_____ _____ _____

6. Please check any of the following items that apply to you:

OSA Symptoms: ☐ Snoring loudly ☐ Tired, sleepy, fatigued during daytime ☐ Breathing stops / Walking & gasping for air ☐ High blood pressure ☐ BMI over 35 kg/m2 ☐ Age over 50 years old ☐ Neck size over 16 inches ☐ Male gender	**RLS Symptoms:** ☐ Aching, crawling in legs/calves at night ☐ Not able to keep legs still at night **PLMD Symptoms:** ☐ Leg twitches or jerks during the night ☐ Waking up with cramps in your legs **Sleep-Wake Schedule Disorder Symptoms:** ☐ Rotating shift work
Scoring: *Yes to 0-2 Low Risk of OSA* _____ *Yes to 3-4: Intermediate Risk of OSA* _____ *Yes to 5-6: High Risk of OSA* _____	**For symptoms checked, further evaluation is required, and may warrant a referral to your PCP or a sleep specialist.*

GOAL SETTING

1. What are your goals for CBT for Insomnia (CBT-1)? *Check all that apply:*

☐ Improve my sleep quality ☐ Get to sleep quicker ☐ Wake up fewer times through the night

☐ Stay asleep until my wake time ☐ Use less sleep medication ☐ Other: _____

ADDITIONAL ASSESSMENT SCREENERS

Insomnia Severity Index (ISI)

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).

	0	1	2	3	4
Insomnia Problem	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
1. Difficulty Falling Asleep	○	○	○	○	○
2. Difficulty Staying Asleep	○	○	○	○	○
3. Problem waking up too early	○	○	○	○	○

	0	1	2	3	4
4. How **SATISFIED OR DISSATISFIED** are you with your *CURRENT* sleep pattern?	**Very Satisfied**	**Satisfied**	**Moderately Satisfied**	**Dissatisfied**	**Very Dissatisfied**
	○	○	○	○	○

	0	1	2	3	4
5. How **NOTICEABLE** to others do you think your sleep 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
6. 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
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**	**A Little**	**Somewhat**	**Much**	**Very Much Interfering**
	○	○	○	○	○

Add up columns: _____+ _____ + _____ + _____ + _____ =

Total ISI: _____

Scoring:

☐ No clinically significant insomnia (0-7)
☐ Subthreshold insomnia (8-14)
☐ Clinical insomnia, moderate severity (15-21)
☐ Clinical insomnia, severe (22-28)

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Please select the best option:

	Never Would Doze Off (0)	Slight Chance of Dozing (1)	Moderate Chance of Dozing (2)	High Chance of Dozing (3)
1. Sitting and Reading	◯	◯	◯	◯
2. Watching TV	◯	◯	◯	◯
3. Sitting inactive in a public place (e.g. theater or meeting)	◯	◯	◯	◯
4. As a passenger in a car for an hour without a break	◯	◯	◯	◯
5. Lying down to rest in the afternoon when circumstances permit	◯	◯	◯	◯
6. Sitting and talking to someone	◯	◯	◯	◯
7. Sitting quietly after a lunch (without alcohol)	◯	◯	◯	◯
8. In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯
TOTAL:	_____	_____	_____	_____

TOTAL: _____

Scoring:

0-10 Normal range in healthy adults ☐

11-14 Mild sleepiness* ☐

15-17 Moderate sleepiness* ☐

18+ Severe Sleepiness* ☐

**Scores of 11 and above likely warrant medical attention.*

BELIEFS OF SLEEP

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, **select a number that best reflects your personal experience.** Consider the whole scale (1-10), rather than only the extremes of the continuum.

1. I need 8 hours of sleep to feel refreshed and function well during the day.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
2. When I do not get the proper amount of sleep on a given night, I need to catch up on the next day by napping or the next night by sleeping longer.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
3. I am concerned that chronic insomnia may have serious consequences for my physical health.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
4. I am worried that I may lose control over my abilities to sleep.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
5. After a poor night's sleep, I know that it will interfere with my daily activities the next day.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
6. In order to be alert and function well during the day, I am better off taking a sleeping pill rather than having a poor night's sleep.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
8. When I sleep poorly one night, I know that it will disturb my sleep schedule for the whole week.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
9. Without an adequate night's sleep, I can hardly function the next day.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
10. I can't ever predict whether I will have a good or poor night's sleep.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
11. I have little ability to manage the negative consequences of disturbed sleep.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
12. When I feel tired, have no energy, or just seem to not function well during the day, it is generally because I did not sleep well the night before.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
13. I believe that insomnia is essentially a result of a chemical imbalance.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
14. I feel that insomnia is ruining my ability to enjoy life and prevents me from doing what I want.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
15. Medication is probably the only solution to sleeplessness.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*
16. I avoid or cancel obligations (social, family, occupational) after a poor night's sleep.	*Strongly Disagree*	○○○○○○○○○○	*Strongly Agree*

Total Score: _____ **Average:** _____

SMITH'S (1989) MEASURES OF MORNINGNESS/EVENINGNESS

Directions: For each item, please check one response that best describes you.

1. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
- ___ a. (5) 5:00-6:30 am
- ___ b. (4) 6:30-7:45 am
- ___ c. (3) 7:45-9:45 am
- ___ d. (2) 9:45-11:00 am
- ___ e. (1) 11:00-12:00 noon

2. Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
- ___ a. (5) 8:00-9:00 pm
- ___ b. (4) 9:00-10:15 pm
- ___ c. (3) 10:15 pm -12:30 am
- ___ d. (2) 12:30-1:45 am
- ___ e. (1) 1:45-3:00 am

3. Assuming normal circumstances, how easy do you find getting up in the morning?
- ___ a. (1) Not easy at all
- ___ b. (2) Slightly easy
- ___ c. (3) Fairly easy
- ___ d. (4) Very easy

4. How alert do you feel after the first half hour after having awakened in the morning?
- ___ a. (1) Not at all alert
- ___ b. (2) Slightly alert
- ___ c. (3) Fairly alert
- ___ d. (4) Very alert

5. During the first half hour after having awakened in the morning, how tired do you feel?
- ___ a. (1) Very tired
- ___ b. (2) Fairly tired
- ___ c. (3) Slightly tired
- ___ d. (4) Not at all tired

6. You have decided to engage in some physical exercise. A friend suggests that you do this one hour twice a week and the best time for him is 7:00-8:00 am. Bearing in mind nothing else but your "feeling best" rhythm, how do you think you would perform?
- ___ a. (4) Would be in good form
- ___ b. (3) Would be in reasonable form
- ___ c. (2) Would find it difficult
- ___ d. (1) Would find it very difficult

7. At what time in the evening do you feel tired and as a result, in need of sleep?
- ___ a. (5) 8:00-9:00 pm
- ___ b. (4) 9:00-10:15 pm
- ___ c. (3) 10:15 pm - 12:30 am
- ___ d. (2) 12:30-1:45 am
- ___ e. (1) 1:45-3:00 am

8. You wish to be at your peak performance for a test, which you know is going to be mentally exhausting and lasting for two hours. You are entirely free to plan your day, and considering only your own "feeling best" rhythm, which ONE of the four testing times would you choose?
- ___ a. (4) 8:00-10:00 am
- ___ b. (3) 11:00 am - 1:00 pm
- ___ c. (2) 3:00-5:00 pm
- ___ d. (1) 7:00-9:00 pm

9. One hears about "morning" and "evening" type people. Which ONE of these types do you consider yourself to be?
- ___ a. (4) Definitely a morning type
- ___ b. (3) More a morning than an evening type
- ___ c. (2) More an evening than a morning type
- ___ d. (1) Definitely an evening type

10. When would you prefer to rise (provided you have a full day's work - (8 hours) if you were totally free to arrange your time?
- ___ a. (4) Before 6:30 a.m.
- ___ b. (3) 6:30 -7:30 a.m.
- ___ c. (2) 7:30 - 8:30 a.m.
- ___ d. (1) 8:30 a.m. or later

11. If you always had to rise at 6:00 am, what do you think it would be like?
- ___ a. (1) Very difficult and unpleasant
- ___ b. (2) Rather difficult and unpleasant
- ___ c. (3) A little unpleasant but no great problem
- ___ d. (4) Easy and not unpleasant

12. How long a time does it usually take before you "recover your senses" in the morning after rising from a night's sleep?
- ___ a. (4) 0-10 minutes
- ___ b. (3) 11-20 minutes
- ___ c. (2) 21-40 minutes
- ___ d. (1) More than 40 minutes

13. Please indicate to what extent you are a morning or an evening active individual?
- ___ a. (4) Very morning active (morning alert & evening tired)
- ___ b. (3) To some extent, morning active
- ___ c. (2) To some extent, evening active
- ___ d. (1) Very evening active {morning tired & evening alert)

TOTAL SCORE: _____

☐ Evening Type (22 and less) ☐ Intermediate Type (23-43) ☐ Morning Type (44 and above)