CDP
Uniformed Services University

Reset Form

Sleep Disorders Interview

Name: Gender: (M) (F) Marital Status: Choose One:

Day Phone: Date of Birth: Education (Yrs):
Yr Mth Day

Referral Source: Interviewer:

Nature of Sleep-Wake Problem

In a typical week… *(Ideally focus on the last week, if the last week was not typical, focus on the most recent typical week).*

Do you have a problem with falling asleep?	☐ No	☐ Mild	☐ Moderate	☐ Severe
Do you have a problem with staying asleep?	☐ No	☐ Mild	☐ Moderate	☐ Severe
Do you have a problem with waking up too early in the morning?	☐ No	☐ Mild	☐ Moderate	☐ Severe
Do you have a problem with staying awake during the day?	☐ No	☐ Mild	☐ Moderate	☐ Severe

Functional Analysis

How many nights a week do you have these sleep difficulties?

Have you noticed any pattern to your sleep difficulties across the week (or month)?

What do you do when you can't fall asleep or return to sleep? Is that helpful for you?

What other treatments or strategies have you tried in the past, and were they helpful for you?

Is your sleep better/worse/same when you go away from home?

After a stressful or bad day, have you found that your sleep is worse or better?

What types of factors make your sleep problem worse (e.g., stress at work, travel plans, emotional tension)?

What types of factors improve your sleep (e.g., vacation, sex, distractions)?

How concerned are you about sleep/insomnia?

What impact does insomnia have on your mood?

What impact does insomnia have on your alertness?

What impact does insomnia have on your performance?

How do you cope with these daytime sequelae?

Have you stopped doing anything (other than sleeping) because of insomnia?

How would your life be different if you didn't have insomnia (e.g., work harder, take care of children)?

Have you received treatment in the past for insomnia (other than medication)?

Many people that we see with similar problems report that their difficulty sleeping not only affects them at night but also during the day, have you found this to be true for you as well?
After a poor night's sleep, which of the following problems do you experience on the next day?

Daytime fatigue: ____ Low physical energy ____ Low mental energy _____ Exhausted

Sleepiness: ____ Propensity to fall asleep ____ Heavy eyes _____ Difficulty staying awake

Difficulty functioning: ____ Performance impairment ____ Poor concentration _____ Memory problems

Mood Problems: ____ Irritable ____ Tense ____ Nervous ____ Depressed ____ Angry

Physical Symptoms: ____ Muscle Aches/Pains ____ Headache ____ Heartburn ____ Light-headed

What prompted you to seek insomnia treatment at this time?

What are your specific goals for insomnia treatment? (longer sleep, fewer nightmares, fall asleep faster)

Because problems sleeping affect us not only at night but also during the day, we have found that it is helpful to talk not only about your sleep at night but also to discuss the impact of a bad night sleep on the next day and the impact of a stressful day on your sleep at night. One of the most effective ways I have found to get a good understanding of all the factors that may be playing a role in your insomnia is to have you walk me through the 24 hours of a typical work day. So lets start with what time you intend to wake up on a typical work day…

At what time do you last awaken in the morning (wake up)? _____ o'clock
How do you usually wake up? Alarm, automatically, child/pet other environmental?

What is your usual arising time on weekdays (get up)? _____ o'clock

What do you typically have for breakfast?
When do you have your first caffeinated beverage?
How much caffeine do you drink on a typical day?

Do you take any medications or vitamins?
What time do you typically leave for work and how is your commute; do you find yourself dozing off?

Describe a typical morning at work. How is your job, what do you do, is your job sedentary or pretty physical, what is the likelihood that you would nod off in the morning at work?

Tell me about breaks at work; do you take breaks? How often and how long? What do you do on breaks?

Do you use tobacco? About how much tobacco do you use in a typical day?

Do you eat lunch at work? What is your typical lunch and how much time do you have? Do you ever nap or unintentionally nod off during lunch?

Describe a typical afternoon at work. Is there a time in the afternoon when you seem most likely to nod off? In what setting?

How many caffeinated beverages do you typically drink in the afternoon?

How is your commute home? Have you ever dozed off or felt very groggy driving home?

How often do you exercise? What type of exercise do you do? What time of day do you typically exercise?

How often do you intentionally nap? Where do you usually nap and for how long?

When do you typically eat dinner?

What types of stress do you experience in a typical evening at home?

How many alcoholic beverages do you drink in a typical day? Around what time do you have your first drink? Around what time do you have your last drink? Have you noticed any changes in your alcohol consumption since your sleep problems began?

What is your typical nighttime routine? What do you do (watch tv, read, play videogames, work/play on the computer)? Who is around with you?

How likely are you to doze or unintentionally nod off during the evening? Where and when does this happen?

When is your last caffeinated beverage?

When do you use tobacco for the last time each night?

How do you decide when to go to bed for the night? Do you have a bed time or do you typically go to bed just whenever you feel sleepy? Do you fall asleep outside of your bed, before deciding to go to bed?

Now let's talk about your bedtime routine. What do you usually do in the 30-60 minutes leading up to your bedtime?

What do you typically do in bed prior to sleeping (tv, read etc)

How long, once you turn out the lights with the intention of falling asleep does it usually take you to fall asleep?

What sort of things seem to interfere with your ability to fall asleep?

Once you fall asleep do you wake up during the night?

What sort of things seem to wake you in the middle of the night?

How often do you wake during the night?

How long are you awake in the middle of the night?

In a moment I am going to ask you some more specific questions about your sleep, however is there anything else that comes to mind now about your typical day, the impact of sleep problems, things that interfere with your sleep or the impact of sleep on your daily functioning?

Now can you tell me how your schedule changes on days that you do not work?

Do your bed and wake times differ? If so, how does your sleep quality change with the different amount or hours of sleep?

How does your bedtime routine differ on nights before your days off?

Are you more or less likely to nap on days off?

How is your daytime functioning and mood different on your days off?

How is your stress level different on your days off?

Let's talk about your bed room environment, imagine standing in the doorway to your bedroom, let's talk about what you see and how it makes you feel.

Do you have a TV, radio, or phone in your bedroom? Do you shut them or silence them before going to sleep?
Do you have a tablet or IPad you use in your bedroom ◯ Yes ◯ No
Do you use any sleep-related technology, such as a self-monitoring device? ◯ Yes ◯ No
Do you have exercise equipment in your room? ◯ Yes ◯ No
Is there a desk with paperwork to be done in your bedroom? ◯ Yes ◯ No
Is your bedroom quiet? ◯ Yes ◯ No
Is your mattress comfortable? ◯ Yes ◯ No
How is your room temperature?
Are you sleeping with a bed partner? ◯ Yes ◯ No
What is your bed partners sleep like?
What do you do in your bedroom besides sleep?
Do you have conversations with your partner in the bedroom or bed? ◯ Yes ◯ No
How do you feel in your bedroom? (anxious, frustrated, sad, restful, calm)

Sleep Problem History

How long have you been suffering from insomnia? ____ years ____ months

Were there any stressful life events related to its onset?

Gradual or sudden onset?

What have been the course of your insomnia problem since its onset
(e.g., persistent, episodic, seasonal, etc.)?

Prior to this current period of insomnia, did you have any sleep difficulties? If so, how were they resolved?

Do you know of any family history of sleep problems? Do you know if/how they were treated?

Sleeping Aids

So let me just clarify a few things we covered in reviewing your typical day…

In the past 4 weeks have you used sleeping medication? ◯ Yes ◯ No

If yes, which drugs?

Prescribed, over-the-counter, or both?

How many nights/week do you use the medication?

If no, have you ever used sleeping medication? ◯ Yes ◯ No

When did you *first* use sleep medication?

When did you *last* use sleep medication?

In the past 4 weeks, have you used alcohol as a sleep aid? ◯ Yes ◯ No

If yes, what type and how many ounces?

How many nights/week?

If no, have you ever used alcohol as a sleep aid? ◯ Yes ◯ No

Symptoms of Other Sleep Disorders *(Note if patient screens positive, refer to specialist for further eval)*

Have you or your bed partner ever noticed one of the following, and if so, how often in a typical week would you estimate you experience these symptoms?

A. *Apnea*: Snoring, pauses in breathing at night, shortness of breath, choking at night, morning headaches, chest pain, dry mouth?
B. *Narcolepsy*: Sleep attacks, sleep paralysis, hypnagogic hallucinations, cataplexy?
C. *Sleep-wake schedule disorder*: Rotating shift or night shift work?
D. *Parasomnias*: Nightmares, night terrors, sleepwalking/talking, bruxism (teeth grinding)?
   If yes to nightmares, had nightmares before trauma? Awaken from nightmares? Frequency of nightmares? Negative affect (eg fear or anxiety)? Severity of nightmares? Have nightmares changed over time?
E. *Restless legs*: Crawling or aching feelings in your legs (calves) and inability to keep legs still?
F. *Periodic limb movements*: Leg twitches or jerks during the night, waking up with cramps in your legs?
G. *Other (Gastro-esophageal reflux, Allergic Rhinitis)*: Sour taste in mouth, heartburn, reflux? Nose blocking up at night, daytime allergies?

Medical History/Medication Use

Current medical problems:

Current medications: Name Amount Frequency Taken Purpose

Hospitalizations/Surgery:

Height: Weight (lbs): Recent Weight Gain/Loss?

History of Psychopathology/Mental Health Treatment *(modified SCID)*

Are you currently receiving psychological or psychiatric treatment for emotional or mental health problems? ◯ Yes ◯ No

Have you or anyone in your family ever been treated for emotional or mental health problems in the past? ◯ Yes ◯ No

Have you or anyone in your family ever been a patient in a psychiatric hospital? ◯ Yes ◯ No

Has alcohol or any drug ever caused a problem for you? ◯ Yes ◯ No

Have you ever been treated for alcohol/substance abuse problems? ◯ Yes ◯ No

Has anything happened lately that has been especially hard for you? ◯ Yes ◯ No

What about difficulties at work or with your family? ◯ Yes ◯ No

Scale for below ? = Inadequate information 1 = Absent or false 2 = Subthreshold 3 = Present

In the last month, has there been a period of time when you were feeling depressed or down most of the day nearly every day?	?	1	2	3
What about being a lot less interested in most things or unable to enjoy the things you used to enjoy? If yes, was it nearly every day?	?	1	2	3
For the past couple of years, have you been bothered by depressed mood most of the day, more days than not? More than half the time?	?	1	2	3
Have you ever had a panic attack, when you suddenly felt frightened, anxious or extremely uncomfortable? If yes, 4 attacks within 1 month?	?	1	2	3
Have you ever been afraid of going out of the house alone, being in crowds, standing in a line, or traveling on buses or trains?	?	1	2	3
Have you ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them?	?	1	2	3
In the last 6 months, have you been particularly nervous or anxious?	?	1	2	3
Do you worry a lot about terrible things that might happen?	?	1	2	3
During the last 6 months, would you say that you have been worrying most of the time (more days than not)?	?	1	2	3

If psychopathology is present, evaluate its onset and temporal course in relation to the sleep disturbance.

Does insomnia occur exclusively during the course of worry/depression episodes? ◯ Yes ◯ No

Case Conceptualization Form

Answer each question and provide a plan to address each case factor described.

	Answer	Plan
1. What factors weaken the sleep drive (e.g., napping)?		
2. What factors impact the circadian clock (e.g., mismatch between circadian tendency and sleep schedule)?		
3. What manifestations of hyperarousal are present?		
4. What unhealthy sleep behaviors are present? (Consider substances, eating, exercise, extended TIB etc.)		
5. What comorbidities affect the patient's presentation and how? (Consider sleep, medical and psychiatric comorbidities).		
6. What medications may impact the patient's sleep/sleepiness? (Consider carryover, tolerance, psychological dependence).		
7. What are the predisposing, precipitating, and maintaining factors?		
8. What other factors are relevant to the patient's presentation?		