Patient Intake Form

Name: _____ Today's Date: ___/___/____
First Last

Address: _____ Phone (H): _____

City: _____ Phone (C): _____

Email: _____ Phone (W): _____

Date of Birth: ___/___/_____ Age: _____ Gender: ☐ F ☐ M

Employer: _____ Occupation: _____

How did you hear about us? Internet: Referral:_____ Other: _____

In case of emergency, who should be notified? _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Sleep Physician: _____ Phone: _____

Sleep Facility: _____ Phone: _____

Date of Baseline Sleep Study: ___/___/_____ CPAP Trial:

Briefly describe your problem with your sleep as you see it.

What is the nature of assistance you expect or desire?

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: ___/___/_____

Have you ever had your sleep evaluated before? Sleep Study Date: ____/____/_____

What were you told your final assessment (diagnosis) was?

What treatment options were you offered?

What prompted today's evaluation?

Have you had any oral surgeries to treat your sleep symptom?

Do you work swing-shift or nighttime shifts?

Please check the appropriate box below:

High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
History of Heart Attack or Stroke	☐ Yes	☐ No
Mood Disorder	☐ Yes	☐ No
Impaired Thinking	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No

Have you ever tried any of the following to help improve your sleep breathing?

CPAP	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Nose Cones or Strips	☐ Yes	☐ No
Side Sleeping	☐ Yes	☐ No
Surgical Treatments	☐ Yes	☐ No

SCALE
0 - Would Never Fall Asleep
1 - Slight Chance of Dozing
2 - Moderate Chance of Dozing
3 - High Chance of Dozing

Sitting and reading	0
Watching television	0
Sitting inactive in a public place (i.e. a theater)	0
A passenger in a car for an hour without a break	0
Lying down to rest in the afternoon when possible	0
Sitting quietly after a lunch without alcohol	0
In a car while stopped for a few minutes in traffic	0
Overall quality of sleep- poor, average, good **TOTAL**	**0**

Patient Signature _____ Date: ____/____/_____