**Charles R. Freeman, Ph.D.; PSY #25414: Sleep, Pain, and Behavioral Medicine Psychologist**

# Behavioral Medicine Intake Form

| PATIENT INFORMATION | EMPLOYER INFORMATION |
|---|---|
| Name: _____ | Are you currently employed? _____ |
| Email: _____ | Name of employer: _____ |
| Phone: _____ | Type of work: _____ |
| Address:_____ | How long have you worked here?_____ |
| City: _____ | |
| State: _____ Zip: _____ | Work Address: _____ |
| Age: _____ DOB: _____ Marital Status: _____ | City: _____ |
| Social Security #: _____ - _____ - _____ | State: _____ Zip:_____ |

## MEDICAL INSURANCE

Provider: _____ Issuer: _____

ID: _____ Name on the card: _____

Provider's Phone: _____ Plan: _____

Our policy and belief is that we have a relationship with you, the patient, and you have a relationship with your medical insurance. Treatments are paid at the end of each session and you can submit your claim to get reimbursed by your insurance.

We will happily provide you with a statement that includes all the codes that your carrier will want to see in order to process your reimbursement. Just add your plan ID number and your social security next to your name before sending in the form.

To help you expedite the information that is relevant to you when you call your insurance, these are the questions you want to ask:

1. *Does my plan have out of network coverage for behavioral medicine?*
2. *What is the coverage? What is my deductible?*
3. *How much have I met for this year?*

**Please let us know if you require a prepared statement for insurance or tax purposes.**

| CREDIT CARD INFORMATION | |
|---|---|
| Card #: _____ | CVV: _____ |
| Expiration Date: _____ | Billing Zip Code: _____ |

***Your information will be kept confidential and will not be used for any other purposes without your prior authorization.***

## 24-HOUR CANCELLATION POLICY

This is to advise you of our office's 24-hour cancellation policy. Due to the limited number of appointment time slots, giving us a 24-hour notice or more allows us to fill your cancellation from the waiting list of patients in need of an appointment.

If you need to cancel your scheduled appointment, please notify us as soon as possible, at the very least, 24 hours before your scheduled appointment. If you cancel an appointment with less than a 24-hour notice you will be charged the fee for the visit.

***By signing below I am agreeing that I have read the above statement and I fully understand the cancellation policy as described above, and authorize Charles R. Freeman to charge my credit card the full fee for the missed appointment.*

**Patient Name (please print): _____**

**Signature: _____ Date: _____**

## HEALTH CONCERN BACKGROUND

Please describe the problem(s) you would like us to help you with: _____

_____

_____

_____

_____

How long ago did this problem(s) begin? Please be specific: _____

_____

_____

What stress, if any, is causing the problem? _____

_____

_____

Emergency contact name: _____

Relationship: _____ Phone: _____

Primary Care Physician Name: _____

Address: _____

Phone: _____

Who were you referred by? _____

## CURRENT PSYCHOLOGICAL SYMPTOMS

Indicate if you have experienced any of the following symptoms or sensations listed below **within the past month.**

**Please rate the severity of the symptoms below from 1 to 10**; 1 meaning the symptom hardly affects you and 10 meaning the symptom affects you very severely.

| Symptom | Severity | Symptom | Severity | Symptom | Severity | Symptom | Severity |
|---|---|---|---|---|---|---|---|
| Depressed | | Irritable | | Loss of Interest in Usual Things | | Excessive Worries | |
| Unhappy | | Forgetful | | Insomnia | | Social Anxiety | |
| Low Motivation | | Appetite Change | | Racing Thoughts | | Obsessive Thinking | |
| Difficulty Concentrating | | Low Self-Esteem | | Impulsive | | Rituals to Lower Anxiety | |
| Difficulty Making Decisions | | Low Sex Drive | | Risk-taking | | Anxiety from Past Trauma | |
| Socially Withdrawn | | Worthless | | Too Much Energy | | Feeling "Numb" | |
| Excessive Sleeping | | Guilty | | Tense | | Flashbacks While Awake | |
| Nightmares | | Suicidal Thoughts | | Restless (pacing) | | Avoiding People | |
| Tearful/Crying Spells | | Self-injurious Behavior | | Angry Outbursts | | Drinking Alcohol to Excess | |
| Fatigue | | Financial Problems | | Legal Trouble | | Relationship Problems | |
| Confused Thoughts / Feelings | | Work or School Problems | | Panic Attacks | | Gambling Problems | |
| Fears Phobias | | Coping with Abuse | | Family Problems | | Hopelessness | |

## Check any of the following physical sensations that often apply:

| Sensation | Does it apply? | Sensation | Does it apply? | Sensation | Does it apply? | Sensation | Does it apply? |
|---|---|---|---|---|---|---|---|
| Headaches | | Dizziness | | Vomiting | | Back Pain | |
| Tingling | | Heart Racing | | Stomach Problems | | Hearing Things | |
| Muscle Spasms | | Blackouts | | Neck Pain | | Visual Disturbances | |
| Muscle Tension | | Flushing | | Trouble Swallowing | | Tics/Twitches | |
| Itchy/Burning Skin | | Excessive Sweating | | Bowel Problems | | Odd Sensations | |
| Dry Mouth | | Chest Pain | | Chronic Pain | | Tremors | |
| Unable to Relax | | Fainting Spells | | Sexual Problems | | Don't like being touched | |

| MARITAL STATUS & CHILDREN | |
|---|---|
| Marital Status: | If married, length of marriage: |
| Length of courtship (dating): | Age of Spouse: |
| Occupation of Spouse: | Have you or your spouse been married before? |
| If you or your spouse have been married before, please explain: | |
| Do you have children? | If yes, how many? |
| If you have children, please list their name(s), age(s), and living arrangements: | |

If married, check all that apply with regard to your current marriage:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Close & Trusting | | Sexual Problems | | Poor Communication | | Alcohol Abuse | |
| Problem Trusting Spouse | | Distant but Loyal | | Physical/ Emotional Abuse | | Cold & Hostile | |

| EXERCISE AND LEISURE TIME | |
|---|---|
| Do you exercise? | If yes, how often? |
| Does something stop you from exercising more? If yes, what? | |
| Please list what you like to do for fun or what you do in your leisure time: | |
| Please list your hobbies: | |

## SOCIAL DEVELOPMENT AND HISTORY

## I. CHILDHOOD

A. Where were you born? _____
B. Where did you grow up? _____
C. I have _____brothers and _____sisters.
D. I was born (circle one): 1st 2nd 3rd 4th other: _____
E. Are your parents divorced? Yes No
F. Who raised you? _____

## II. PARENTS

A. Father:
   a. Age: _____
   b. Occupation: _____
   c. If deceased: age, date & cause of death: _____
   d. My childhood relationship with him was: _____
B. Mother:
   a. Age: _____
   b. Occupation: _____
   c. If deceased: age, date & cause of death: _____
   d. My childhood relationship with her was: _____
C. Stepparents (if applicable):
   a. My relationship with my stepfather is/was: _____
   b. My relationship with my stepmother is/was: _____

## III. SUBSTANCE USE HISTORY

A. Do you consume alcohol? _____
B. If yes, how many drinks do you have on an average weekday? _____
C. How many drinks do you have on an average weekend night? _____
D. Have you ever used street drugs or illicit substances? _____
   a. If yes, what have you used?_____When? _____
E. Do you have a history of treatment/evaluation for alcohol/drug-related problems? When? _____
F. Have you been seen for gambling problems?_____When? _____
G. Do you smoke cigarettes?_____If yes, how many per day? _____
H. Have you ever used other tobacco products (cigar, pipe chewing tobacco)?
   a. If yes, what have you used, when & how often?
I. Average number of caffeinated drinks per day:_____

## INPATIENT PSYCHIATRIC OR CHEMICAL DEPENDENCY TREATMENT

| Reason for impatient treatment | Dates | For how long? | Name of hospital |
|---|---|---|---|
| | | | |

**List any medications, past or current, for any emotional problems:**

| Medication & Dosage | Purpose | For how long? |
|---|---|---|
| | | |

## MEDICAL HISTORY

1. How would you describe your current health (circle one)?

   Excellent Good Fair Poor

2. Please check the following that best describes how you care for yourself (circle one)

   Good Pretty Good OK Not at all

3. Please list any current and/or chronic medical problems, surgeries, or significant injuries:

4. Current medications (include over-the-counters and supplements):

5. Have you ever had a concussion, head injury, or lost consciousness? If yes, please explain:

6. Last physical exam:

**SLEEP ASSESSMENT QUESTIONNAIRE**

**General Sleep Information:**

1. What time do you usually go to bed on weekdays? _____
2. How long does it usually take you to fall asleep? _____
3. How many times do you usually wake up in the mornings? _____
4. How many hours of sleep do you usually get? _____
5. Do you need an alarm clock to wake up? _____
6. Do you often wake up in the morning with a headache? _____
7. What time do you usually go to bed on the weekends? _____
8. What time do you usually wake up on the weekends? _____

**Night Time Symptoms** (*Circle the best answer that applies):*

1. Do you snore loudly at night? Never Sometimes Most of the time Always
2. Does your snoring affect others sleeping near you? Never Sometimes Most of the time Always
3. Do you ever stop breathing in your sleep? Never Sometimes Yes, frequently
4. Do you ever wake up choking? No Yes
5. Do you grind your teeth in your sleep? No Yes
6. Do you walk or talk in your sleep? No, neither Walk Talk Yes, both
7. Do your legs jerk when you sleep? No Yes
8. Have you ever been unable to move shortly after going to sleep or when waking up?
   Never Sometimes Most of the time Always
9. As an adult, have you ever wet the bed during your sleep? No Yes
10. How many times do you awaken at night to go to the bathroom? Never 1-2 1-3 5+

**Daytime Symptoms:**

1. Are you drowsy during the day? Never Sometimes Most of the time Always
2. Do you sleep during the day? Never Sometimes Most of the time Always
3. Does daytime sleepiness interfere with your work? No Yes
4. Have you ever fallen asleep during driving? No Yes
   or eating? No Yes
5. How many naps (if any) do you take per day?
6. Does a nap make you feel more alert? No Yes

7. Do you have vivid dreams during those daytime naps? No Yes
8. Do you drink coffee, tea, cola, or take any kind of caffeine to stay awake? No Yes
9. Do you ever fall or lose muscle strength while laughing? No Yes

**Emotional:**

1. Do you now have, or have you in the past had, serious depression? _____
2. Do you now have, or have you in the past had, major anxiety? _____
3. Does your difficulty with sleeping cause emotional problems such as irritability, anxiety, depression, etc.)? _____
4. Are you currently under stress because of work or family?

**Medication & Habits:**

1. Do you smoke cigarettes? No Yes
   if yes, how many per day? _____
2. How much alcohol do you drink per day on average?_____drinks/day
3. Do you drink alcohol after dinner or near bedtime? No Yes
4. Do you exercise strenuously in the evening? No Yes
5. Do you work rotating work shifts? No Yes
6. Do you travel extensively across time zones? No Yes

**Past & Family History:**

1. Does anyone else in your family have similar sleep problems? No Yes
2. How many years have you been aware of the sleep problems? _____
3. Have you gained weight since you have been aware of the sleep problems? No Yes
   If yes, how much weight have you gained? _____
4. Have you ever had your tonsils/adenoids taken out? No Yes
5. Do you have high blood pressure? No Yes