A Vital Life/ A Good Night's Sleep, LLC Dr. Valerie Stone, PhD 720-414-0242
8800 Ralston Rd, Suite 204, Arvada, CO 80007 drvstone.com

Intake Questionnaires

Client Name ______________________________ Today's Date ___________

Address ______________________________ Birthdate ______________

______________________________ Phone _______________

Emergency contact: ____________________________ ________________
Ideally someone local Name Phone

Relationship to me: ______________________________
(e.g., roommate, landlord, friend, relative, spouse, parent)

The following demographic questions are asked in a relatively non-categorical way, recognizing that people don't fit neatly into boxes. Sometimes it can be helpful for me to know this information so I can work with you in an appropriate and sensitive way. You are welcome to decline to answer any question.

Gender identity: ______________________________
(e.g., non-binary, female, male, transgender, fluid, intersex, prefer not to say)

Sexual orientation: ______________________________
(e.g., bisexual, lesbian, gay, queer, heterosexual, prefer not to say)

Ethnic identity: ______________________________
(e.g., African descent, Latino/a/x, Korean, South Asian, African American, Native American, Persian, Northern European, Irish, Mediterranean, etc., prefer not to say)

Spirituality or faith: ______________________________
(e.g., spiritual but not religious, Catholic, Buddhist, atheist, agnostic, Zoroastrian, Jewish, etc., prefer not to say)

Subcultures you belong to or identify with: ______________________________
(e.g., hunter, military veteran, artist, Burner, evangelical Christian, etc., prefer not to say)

Occupation/work: ______________________________
(e.g., teacher, manufacturing, gardening, retail, raising children, farmer, etc., prefer not to say)

Employment status now: ______________________________
(e.g., full time, part time, retired, unemployed, etc.)

Questions that may be relevant to your mood and sleep:

What activities or hobbies do you really enjoy doing? (e.g., knitting, folk dance, hiking, skiing, collecting insects, crafting, journaling, drinking coffee, hanging out with friends)

What is your diet typically like? (e.g., standard American diet, pretty healthy, pre-prepared meals, vegetarian, gluten-free, a lot of fast food, Mediterranean diet, keto, etc.)

Questions about your mood and mental health:

Have you ever been diagnosed with a mood or other mental health condition? (for clients transferring from Sutherland Center, you can just write: "See Sutherland records")

If so, what was the diagnosis? (e.g. depression, bipolar I, bipolar II, cyclothymia, PTSD, anxiety disorder, etc.) (for clients transferring from Sutherland Center, you can just write: "See Sutherland records")

When did this diagnosis occur? (for clients transferring from Sutherland Center, you can just write: "See Sutherland records")

What previous treatment have you had for mental health? (e.g., medication, psychotherapy, group therapy, etc.) (for clients transferring from Sutherland Center, you can write: "See Sutherland records" for therapy received at Sutherland)

Questions about your health:

What medications are you currently taking? Include over-the-counter medicines, like allergy medicines, vitamins, or supplements.

Medication/supplement	**Dose**	**When taken & how often**	**Why taken**
e.g. Vitamin D	1,000 IU	In the a.m., 1x/day	General health
e.g. cetirizine (generic Zyrtec)	10 mg	Evening, 1x/day	Seasonal allergies

In treating mental health issues, it can be helpful to know what else might be going on.

Check any of the conditions below that you have ever had or been diagnosed with.

___ Stroke

___ Concussion, head injury, brain injury

___ Dementia (Alzheimer's, vascular dementia, other)

___ Other neurological condition

Specify ______________________

___ Autism spectrum or Asperger's syndrome

___ Attention Deficit Hyperactivity (ADHD)

___ Other learning disability

___ Narcolepsy

___ Central sleep apnea

___ Anorexia, bulimia, or related condition

___ Fibromyalgia

___ Chronic pain

___ Chronic fatigue

___ Arthritis

___ Broken bones

___ Torn ligaments or tendons

___ Asthma

___ Restless legs syndrome

___ Obstructive sleep apnea

___ Any circadian rhythm syndrome

Are you allergic to cats? _____________ Are you allergic to dogs?_____________

(Relevant in case any other client requests to bring in a therapy animal, I need to know whether to say no because of allergies)

Are there any other medical factors that you think might be affecting your mood? (Questionnaires on following pages ask about stress, so you do not need to list that here.)

On the following pages are questionnaires that will be helpful to me in working with you.

Insomnia Severity Index

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).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/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
0	1	2	3	4

Used via courtesy of www.myhealth.va.gov with permission from Charles M. Morin, Ph.D., Université Laval, Qeubec, Canada

Sleep Need Questionnaire

Client Name ____ Date ____________________

Please answer these questions based on your experience during the previous week.

This past week:	Never 1	Rarely 2	Sometimes 3	Frequently 4	Always 5
Did you feel tired or fatigued (low energy) during the day or evening before bedtime?					
Were you sleepy or drowsy (eyelids heavy) during the day or evening before bedtime?					
Did you take any naps or fall asleep briefly during the day or evening before bedtime?					
Did you feel you had been getting an adequate amount of sleep?					

Used via courtesy of www.myhealth.va.gov, adapted with permission from Arthur J. Spielman, PhD, The City College of New York

A numeric measure of personal stress can be determined by using a variety of instruments that have been designed to help measure individual stress levels. One of these is the Perceived Stress Scale, originally developed in 1983, which can help show how different situations affect feelings and perceived stress.

Perceived Stress Scale

The questions in this scale ask about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question.

The best approach is to answer fairly quickly. That is, don't try to count up the number of times you felt a particular way; rather indicate the alternative that seems like a reasonable estimate.

Put a ✓ or an **X** in the appropriate box:	Never 0	Almost never 1	Some-times 2	Fairly often 3	Very often 4	
l. In the last month, how often have you been upset because of something that happened unexpectedly?						
2. In the last month, how often have you felt that you were unable to control the important things in your life?						
3. In the last month, how often have you felt nervous and stressed?						
4. In the last month, how often have you felt confident about your ability to handle your personal problems?						R
5. In the last month, how often have you felt that things were going your way?						R
6. In the last month, how often have you found that you could not cope with all the things that you had to do?						
7. In the last month, how often have you been able to control irritations in your life?						R
8. In the last month, how often have you felt that you were on top of things?						R
9. In the last month, how often have you been angered because of things that happened that were outside of your control?						
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?						

Used with permission from the State of New Hampshire Employee Assistance Program.

On the next two pages are NIH (National Institutes of Health) questionnaires used to measure life satisfaction and mood. Both questionnaires are publicly available with permission to use them.

Domain-Specific Life Satisfaction (Ages 18+) – Fixed Form

Please respond to each question or statement by marking one box per row.

	Indicate how much you agree or disagree…	Not at all	A little bit	Somewhat	Quite a bit	Very much
PA077	I am satisfied with my education...............	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA078	I am satisfied with my present job or work...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA079	I am satisfied with my well-being from spiritual, religious or philosophical beliefs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA080	I am satisfied with my housing.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA081	I am satisfied with my family life	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA082	I am satisfied with my health	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA083	I am satisfied with my friends and social life...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA084	I am satisfied with my neighborhood overall...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA085	I am satisfied with my ability to help others	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA086	I am satisfied with my achievement of my goals	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA087	I am satisfied with my leisure	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA088	I am satisfied with my physical safety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PA089	I am satisfied with my energy level	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Please respond to each question or statement by marking one box per row.

	In the past 7 days…	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDDEP29	I felt depressed…………………………....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP41	I felt hopeless……………………………	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP09	I felt that nothing could cheer me up……..	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP48	I felt that my life was empty……………...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP04	I felt worthless……………………………	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP36	I felt unhappy……………………………	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP39	I felt I had no reason for living…………....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP45	I felt that nothing was interesting………....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Please respond to each question or statement by marking one box per row.

	In the past 7 days…	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
Anxiety13	I was short of breath	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Anxiety24	I felt nauseous...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Anxiety25	I felt dizzy or lightheaded..........................	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Anxiety28	My muscles twitched or trembled	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Anxiety31	My heart was racing or pounding..............	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Anxiety34	My muscles were tense or sore	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Thoughts about suicide are common – most people in the U.S. have had a period of time where they had such thoughts. This is a questionnaire from the STABLE Project (Standards for Bipolar Excellence Project), used to measure thoughts and behaviors related to suicide. Colorado has a 24-hour/365-day/year Crisis Line if you feel you are in danger of acting on such thoughts very soon: 1-844-493-8255 or text T-A-L-K to 38255.
(This questionnaire is publicly available with permission to use it.)

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

© Osman et al (1999) Revised. Permission for use granted by A.Osman, MD

This set of questions below is optional to do ahead of time. It may be useful for you, or it may be interesting to do during a session.

Instructions

The goal of this exercise is to increase awareness of what really matters to you by identifying your top five life values. Values are the answer to the questions: What's important to you in your life? What is your life's purpose? What do you enjoy doing? When do you feel satisfied and fulfilled? Being aware of your values by answering the above questions will help you navigate your life in the direction that you choose. You have the potential to live the life of your dreams, but how do you do this without looking inward? Understanding our own core values help guide us towards our passions and desires. Please complete the five steps below.

1. Take ten minutes to brainstorm what your own values are without referring to the list on the next page.

   My values are:

   ....

   ....

   ....

   ....

   ....

2. Review the values list on the next page and check those values that resonate with you.

3. This list is always a work-in-progress. If you wish, you may add other values from your brainstorming session or those that you think of along the way through this process:

   ....

   ....

   ....

   ....

   ....

Values list:

- Acceptance
- Achievement
- Advancement & Promotion
- Adventure
- Affection
- Altruism
- Arts
- Awareness
- Beauty
- Challenge
- Change
- Community
- Compassion
- Competence
- Competition
- Completion
- Connectedness
- Cooperation
- Collaboration
- Country
- Creativity
- Decisiveness
- Democracy
- Design
- Discovery
- Diversity
- Environmental Awareness
- Economic Security
- Education
- Effectiveness
- Efficiency
- Elegance
- Entertainment
- Enlightenment
- Equality
- Ethics
- Excellence
- Excitement
- Experiment
- Expertise
- Exhilaration
- Fairness
- Fame
- Family Happiness
- Fast Pace
- Freedom
- Friendship
- Fun
- Grace
- Growth
- Harmony
- Health
- Helping Others
- Helping Society
- Honesty
- Humour
- Imagination
- Improvement
- Independence
- Influencing Others
- Inner Harmony
- Inspiration
- Integrity
- Intellect
- Involvement
- Knowledge
- Leadership
- Learning
- Loyalty
- Magnificence
- Making a Difference
- Mastery
- Meaningful Work
- Ministering
- Money
- Morality
- Mystery
- Nature
- Openness
- Originality
- Order
- Passion
- Peace
- Personal Development
- Personal Expression
- Planning
- Play
- Pleasure
- Power
- Privacy
- Purity
- Quality
- Radiance
- Recognition
- Relationships
- Religion
- Reputation
- Responsibility & Accountability
- Risk
- Safety & Security
- Self-Respect
- Sensibility
- Sensuality
- Serenity
- Service
- Sexuality
- Sophistication
- Spark
- Speculation
- Spirituality
- Stability
- Status
- Success
- Teaching
- Tenderness
- Thrill
- Unity
- Variety
- Wealth
- Winning
- Wisdom

From tools.positivepsychology.com. Used with permission.