# WELL BEING SYSTEMS, PLLC
# PATIENT – CLIENT INFORMATION

LEGAL Name_____ Date of Birth_____
(must match insurance card)

Address_____ City_____ State_____ Zip_____

Mailing Address_____ City_____ State _____ Zip_____
(If different)

Phone: Cell _____ Home _____
Appt. reminders are text, voice and email

Email: _____

Person responsible for your account _____ relationship_____

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Ethnicity (circle): Hispanic_____ Non-Hispanic_____ Race:_____ I choose not to answer_____

Preferred language:_____

Relationship status: Single Married Partnered

Name of Spouse/Partner (parents/guardian for minor)_____

Children & Ages (siblings for minor) _____

I GIVE PERMISSION FOR DR BURSTEIN TO RELEASE AND/OR RECEIVE MEDICAL OR FINANCIAL INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION, TO THE FOLLOWING PEOPLE, NOT INCLUDING HEALTH CARE PROVIDERS: (***OPTIONAL***)

NAME _____ RELATIONSHIP_____ Patient Initials _____

NAME _____ RELATIONSHIP_____ Patient Initials _____

Please note: Separate authorization form needed to release/receive information from health care providers. This form will be given upon request.

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Name of referring physician _____

In case of emergency notify _____ Relationship_____Phone_____

REFERRED BY - IF OTHER THAN YOUR DOCTOR_____

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Please explain why you are seeking help at this time:

_____
_____

Please explain how your problems are affecting your work and relationships, plus your general functioning:

_____
_____
_____
_____

Patient name_____ Date of Birth_____

**On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now: _____**

Please check any health problems you have or have had:

| | | |
|---|---|---|
| _____lung | _____high blood pressure | _____arthritis |
| _____liver | _____diabetes | _____other pain |
| _____kidney | _____seizures | _____cancer |
| _____stomach/intestinal | _____head injury | |

Medicines you are allergic to:

_____
_____

Medicines you now take:

_____
_____
_____
_____

How much and what kind of exercise you get:

_____
_____

Height _____ Weight _____

| **SUBSTANCE USE** | Average amount Past 2 months | Most ever used |
|---|---|---|
| Coffee | _____ | _____ |
| Cigarettes | _____ | _____ |
| Alcohol | _____ | _____ |
| Recreational Drugs | _____ | _____ |

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

| | | |
|---|---|---|
| ___Physical health | ___ In-law problems | ___Using drugs |
| ___Chronic Pain | ___ Job or school performance | ___Panic Attacks |
| ___ Low mood | ___Friendships | ___Phobias |
| ___ Mood swings | ___Financial problems | ___ Anxiety symptoms |
| ___ Energy/motivation level | ___ Obsessions (unwanted thoughts) | ___*sweating* |
| ___ Memory | ___ Nightmares | ___ *short of breath* |
| ___ Concentration | ___ Thoughts of hurting someone | ___ *stomach upset* |
| ___ Sleep | ___ Compulsions (unwanted actions) | ___*dizziness* |
| ___ Sexual functioning | ___ Flashbacks | ___ *choking* |
| ___Suicidal thoughts | ___ Paranoid thoughts | ___ *racing heart* |
| ___ Spirituality/religion | ___ Domestic violence (verbal) | ___ *weakness* |
| ___ Marriage/relationship | ___ Domestic violence (physical) | ___*dry mouth* |
| ___ Family conflicts | ___ Drinking alcohol | ___ *feeling trapped* |
| | | ___ *panic* |

Patient Name _____ Date of Birth_____

For the following, please circle YES or NO and give details:

Have you had counseling or psychotherapy in the past? YES - NO _____
Have you ever taken medication for your emotional or mental health? YES – NO _____
Have you ever been hospitalized for psychiatric problems? YES – NO _____
Have you ever been arrested? YES – NO _____
Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES – NO
_____
Have you ever had any experiences that you would consider traumatic or abusive? YES - NO
_____
Have you ever tried to kill yourself or hurt yourself in any way? YES – NO _____
Is there any danger these days that you might hurt yourself or someone else? YES – NO _____

Please describe your education:
_____

Please describe the family you grew up in including your parents and names and ages of your siblings:
_____
_____
_____
_____

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:
_____
_____
_____
_____

Please describe your support system (family you are close to, friends you talk with, etc.):
_____
_____

What is your current job and how do you like it?
_____
_____
_____

Please describe your religious affiliation and practice, if any:
_____
_____
_____

# SLEEP QUESTIONAIRE – PLEASE COMPLETE IF YOU HAVE A SLEEP PROBLEM

Name_____ Date of Birth_____

What is the main problem with your sleep? _____
Are you a shift worker? **YES** or **NO** If so, what hours do you work? _____
On average, how many hours of sleep do you get in 24 hours? _____
All at once or with naps? _____ Is this enough? **YES** **NO** Or too much? **YES** **NO**

## INSOMNIA - POOR SLEEP QUALITY

Do you have problems getting to sleep or staying asleep? **YES** **NO**
If so, is your main problem getting to sleep, or waking up too much, or both? _____
Do you tend to sleep at the wrong time; that is, are you an extreme night owl or morning lark? **YES** **NO**
If so, what is your best window of time for sleeping? _____
Do you legs or arms itch, burn, tingle or just feel "fidgety" when you are trying to sleep? **YES** **NO**

## EXCESSIVE SLEEP OR SLEEPINESS

Are you often too sleepy when you need to be awake? **YES** **NO**

On your usual schedule in recent weeks or months, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to answer according to how you think they might affect you. Choose the most appropriate number for each situation:
**0 = would never doze** **1 = slight chance of dozing** **2 = moderate chance** **3 = high chance of dozing**

| | | |
|---|---|---|
| Sitting & reading | 0 1 2 3 | |
| Watching TV | 0 1 2 3 | |
| Sitting in a public place, like a waiting room | 0 1 2 3 | The Epworth Sleepiness Scale |
| Riding in a car for 1 hour | 0 1 2 3 | (John, M.W. (1993) Chest 103:30-36) |
| Lying down to rest | 0 1 2 3 | |
| Sitting & talking | 0 1 2 3 | |
| Sitting after lunch without alcohol | 0 1 2 3 | |
| Driving a care while stopped in traffic | 0 1 2 3 | |
| **Total Score** | _____ | |

If your score is 10 or higher, a sleep disorders consultation is recommended.

Other situations in which you fall asleep when you don't mean to? _____

Do you snore? **YES** **NO** Loudly enough to disturb others? **YES** **NO** Stop Breathing? **YES** **NO**

## SLEEP BEHAVIORS and OTHER PROBLEMS

Do your legs or arms twitch or jerk during sleep? **YES** **NO** Whole body? **YES** **NO**
If either, do these twitches or jerks seem to interfere with your sleep? **YES** **NO**
Do you sleepwalk or act out dreams: **YES** **NO**
Do you fall out of bed or have unusual movements during sleep? **YES** **NO**
Have you ever injured yourself or someone else while asleep? **YES** **NO**
Do you have nightmares? **YES** **NO**

# MOOD DISORDER QUESTIONAIRE

**Patient Name _____ Date of Birth _____**

Has there ever been a period of time when you were not your usual self and
……

| | | |
|---|---|---|
| You felt so good or so hyper that other people though you were not your normal self or you were so hyper that you got into trouble? | ○ yes | ○ no |
| You were so irritable that you shouted at people or started fights or arguments? | ○ yes | ○ no |
| You felt much more self confident than usual? | ○ yes | ○ no |
| You got much less sleep than usual and found you didn't miss it? | ○ yes | ○ no |
| You were much more talkative or spoke much faster than usual? | ○ yes | ○ no |
| Thoughts raced through your head or you couldn't slow down your mind? | ○ yes | ○ no |
| You were so easily distracted by things around you that you had trouble concentrating or staying on track? | ○ yes | ○ no |
| You had much more energy than usual? | ○ yes | ○ no |
| You were much more active or did many things more than usual? | ○ yes | ○ no |
| You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | ○ yes | ○ no |
| You were much more interested in sex than usual? | ○ yes | ○ no |
| You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | ○ yes | ○ no |
| Spending money got you or your family into trouble? | ○ yes | ○ no |

…….....

| | | |
|---|---|---|
| **If you checked YES to more than one of the above, have several of these ever happened during the same period of time?** | ○ yes | ○ no |

**How much of a problem did any of these cause you – like being able to work; having family, money or legal troubles, getting into arguments or fights?**

○ No Problem ○ Minor Problem ○ Moderate Problem ○ Serious Problem