

ALVIN C. BURSTEIN, MD
PATIENT – CLIENT INFORMATION

LEGAL Name _____ Date of Birth _____

Preferred Name (if different from legal name) _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____
(If different)

Phone: Primary _____ Secondary _____
(Best place to reach you or leave a message)

Person responsible for your account _____ relationship _____

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 _____

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

Name of referring physician _____

In case of emergency notify _____ Relationship _____ Phone _____

REFERRED BY - IF OTHER THAN YOUR DOCTOR _____

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:

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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

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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 QUESTIONNAIRE –
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 your 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 (John, M.W. (1993) Chest 103:30-36)
Riding in a car for 1 hour	0	1	2	3	
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 QUESTIONNAIRE

Patient Name _____ Date of Birth _____

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

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You felt so good or so hyper that other people thought 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

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2. 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

3. 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