Appleton Clinic

PATIENT DEMOGRAPHIC/INTAKE FORM

Welcome To Our Office	NEW PATIENT INFORMATION			Date: (MONTH/DAY/YEAR):			
PATIENT'S NAME (PLEASE PRINT)	S.S.#	Marital Status		Sex	Birth Date	Age	Religion (Optional)
		S M W D Sep		M F			
STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE #				
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUS. PHONE # EXT. # / CELL PHONE NO.				
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE					
DRUG ALLERGIES, IF ANY:	EMAIL ADDRESS:						
SPOUSE / PARENT'S NAME/NEXT OF KIN	HOW ARE YOU RELATED?	TEL NUMBER:					
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUS. PHONE #				
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE					
*SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED	CITY AND STATE	ZIP CODE	HOME PHONE #				

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF I DO NOT GIVE AT LEAST 24 HRS NOTICE OF CANCELLATION I MAY BE BILLED THE FULL FEE FOR MY MISSED APPOINTMENT. CALLS MADE AFTER HOURS THAT NEED TO BE RETURNED BY PHYSICIAN ARE CHARGED A $50.00 FEE.

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE		ZIP CODE	HOME PHONE #
IF INSURANCE COMPANY (NAME OF POLICY HOLDER) ☐	EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE
WRITE IN NAME OF INSURANCE COMPANY PLEASE ☐	EFFECTIVE DATE		POLICY #	
TELEPHONE NUMBER OF INSURANCE COMPANY:				
HOW DID YOU FIND OUT ABOUT US?				

WAS THIS A RESULT OF AN ACCIDENT? ☐ YES ☐ NO	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	DATE OF ACCIDENT	NAME OF ATTORNEY/TELEPHONE NO.
	IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.)	DATE X-RAYS TAKEN	

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

Signature_____ Date _____

Appleton Clinic / Sleep and Fatigue Treatment Center
2499 Glades Rd., Suite 110, Boca Raton, FL 33431
Tel: (561) 450-8328 Fax: (561) 450-5817

Appleton Clinic

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Appleton Clinic / Sleep and Fatigue Treatment Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and can be provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Sleep and Fatigue Treatment Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Sleep and Fatigue Treatment Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Sleep and Fatigue Treatment Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

_____ _____

Patient's Signature (authorized representative signing for the patient) Date

THIS PAGE IS FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

TPO CONSENT FORM

Disclosure of Protected Health Information Log

Date	Time	Name of Requestor (Include Business Information)	Reason for Request	Information Requested* (BE SPECIFIC)	Known?	Approved By/D (If Applicable
					Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

Appleton Clinic

CES-D: Name: _____ Date: _____

Below is a list of the ways you might have felt or behaved. Circle the corresponding number to indicate how often you have felt this way DURING THE PAST WEEK.

0 Rarely or None of the Time *(Less than I Day)*
1 = Some or a Little of the Time (1-2 *Days)*
2 = Occasionally or a Moderate Amount of Time (3-4 *Days)*
3 = Most or All of the Time (5-7 *Days)*

DURING THE PAST WEEK:	*Rarely or None of the Time*	*Some or a Little of the Time*	*Occasionally or a Moderate Amount*	*Most or All of the lime*
1. I WAS BOTHERED BY THINGS THAT USUALLY DON'T BOTHER ME	0	1	2	3
2. I DID NOT FEEL LIKE EATING; MY APPETITE *WAS* POOR	0	1	2	3
3. I FELT THAT I COULD NOT SHAKE OFF THE BLUES EVEN WITH HELP FROM *MY* FAMILY OR FRIENDS	0	1	2	3
4. I FELT THAT I WAS JUST AS GOOD AS OTHER PEOPLE	0	1	2	3
5. I HAD TROUBLE KEEPING MY MIND ON WHAT I WAS DOING	0	1	2	3
6. I FELT DEPRESSED	0	1	2	3
7. I FELT THAT EVERYTHING I DID WAS AN EFFORT	0	1	2	3
8. I FELT HOPEFUL ABOUT THE FUTURE	0	1	2	3
9. I THOUGHT MY LIFE *HAD* BEEN *A* FAILURE	0	1	2	3
10. I FELT FEARFUL	0	1	2	3
11. MY SLEEP WAS RESTLESS	0	1	2	3
12. I WAS HAPPY	0	1	2	3
13. I TALKED LESS THAN USUAL	0	1	2	3
14. I FELT LONELY	0	1	2	3
15. PEOPLE WERE UNFRIENDLY	0	1	2	3
16. ENJOYED LIFE	0	1	2	3
17. I HAD CRYING SPELLS	0	1	2	3
18. I FELT SAD	0	1	2	3
19 I FELT THAT PEOPLE DISLIKED ME	0	1	2	3
20. I COULD NOT GET "GOING"	0	1	2	3

TOTAL: _____

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FATIGUE SEVERITY SCALE

Using the following scale, circle the most appropriate number in the chart.

1 = Completely Disagree 4 = Neither Agree now Disagree 7 = Completely Agree

DURING THE PAST WEEK, I HAVE FOUND THAT:	*Completely Disagree*			*Neither Agree/ Nor Disagree*			*Completely Agree*
1. My motivation is lower when I am fatigued	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

Total:

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NAME:_____ DATE: _____
(Month/Date/Year)

ZUNG ANXIETY SCALE

How often has each of the following statements applied to you during the last 2 weeks?

0 = None or a little 1 = Some of the Time 2 = Good Part of the Time 3 = Most, or All, of the Time of the time

	None of the Time		Most of the time	
1. I FEEL MORE NERVOUS AND ANXIOUS THAN USUAL	0	1	2	3
2. I FEEL AFRAID FOR NO REASON AT ALL	0	1	2	3
3. I GET UPSET EASILY OR FEEL PANICKY	0	1	2	3
4. I FEEL LIKE I'M FALLING APART AND GOING TO PIECES	0	1	2	3
5. I FEEL THAT EVERYTHING IS ALL RIGHT AND NOTHING BAD WILL HAPPEN	0	1	2	3
6. MY ARMS AND LEGS SHAKE AND TREMBLE	0	1	2	3
7. I AM BOTHERED BY HEADACHES, NECK AND BACK PAINS	0	1	2	3
8. I FEEL WEAK AND GET 'TIRED EASILY	0	1	2	3
9 I FEEL CALM AND CAN SIT STILL EASILY	0	1	2	3
10. I CAN FEEL MY HEART BEATING FAST	0	1	2	3
11. I AM BOTHERED BY DIZZY SPELLS	0	1	2	3
12. I HAVE FAINTING SPELLS OR FEEL LIKE FAINTING	0	1	2	3
13. I CAN BREATHE IN AND OUT EASILY	0	1	2	3
14. I GET FEELINGS OF NUMBNESS AND TINGLING IN MY FINGERS AND TOES	0	1	2	3
15 I AM BOTHERED BY STOMACH ACHES OR INDIGESTION	0	1	2	3
16. I HAVE TO EMPTY MY BLADDER OFTEN	0	1	2	3
17. MY HANDS ARE USUALLY DRY AND WARM	0	1	2	3
18. MY FACE GETS HOT AND BLUSHES	0	1	2	3
19. I FALL ASLEEP EASILY AND GET A GOOD NIGHT'S REST	0	1	2	3
20. I HAVE NIGHTMARES	0	1	2	3

Total Score: _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Appleton Clinic

Sleep and Fatigue Treatment Center
Drug of Abuse Testing Consent Agreement

This drug of abuse testing consent agreement is made between the patient listed below and Sleep and Fatigue Treatment Center. Patient reserves the right to be randomly drug screened when the doctor suspects possible involvement or influence of drugs and if the patient is taking a controlled substance. I understand that I am responsible for the cost of the drug test which is $50.00.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

_____ ____/____/_____
Patient's Name (Printed) Date of Birth

_____ ____/____/_____
Patient's Signature Today's Date

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Sleep and Fatigue Treatment Center
Cancellation and No Show Policy

I.) Cancellation of an Appointment

Please be courteous and call promptly if you are unable to attend an appointment. This time will be reallocated to someone who needs to come in to see Dr. Appleton. If it is necessary to cancel your scheduled appointment, we require that you call or email us 24 business hours in advance. If you call for a refill on one of your medications that results in the cancellation of your follow up appointment with the doctor, you will be charged in full for the missed appointment.

II.) How to Cancel Your Appointment

To cancel appointments, please call **(561) 450-8328** or feel free to email us at **reception@sleepandfatigue.com**. If you do not reach a member of the office staff, you may leave a detailed message on the company voice mail.

III.) No Show Policy

A "No Show" is someone who misses an appointment without canceling it 24 business hours in advance of your scheduled appointment. (Example: your appointment is at 3 pm on Tuesday. You need to call or email us by 3 pm on Monday). No-shows inconvenience those individuals who need to come in to see Dr. Appleton. A failure to present at the time of a scheduled appointment will be recorded in your chart as a "No Show". I agree to pay in full for any missed appointment.

_____ ____/____/_____
Patient's Name (Printed) Date of Birth

_____ ____/____/_____
Patient's Signature Today's Date

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Sleep and Fatigue
Treatment Center
Sleep well. Awake refreshed.

NAME:_____ DATE: _____
(Month/Date/Year)

EPWORTH SLEEPINESS SCALE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS IN CONTRAST TO FEELING JUST TIRED?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate out how they would have affected you. Using the following scale, circle the most appropriate number in the chart for each situation.

0 = *would NEVER doze* 1 = *SLIGHT chance of dozing* 2 = *MODERATE chance of dozing* 3 = *HIGH chance of dozing*

SITUATION	CHANCE OF DOZING			
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting, inactive in a public place (e.g. *theatre or a meeting)*	0	1	2	3
4. *As a* passenger in *a car for an hour without a* break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit.	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after a lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

Total:

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Sleep and Fatigue
Treatment Center
Sleep well. Awake refreshed.

SLEEP HISTORY

Bring this form with you to your sleep evaluation with the doctor please.

Please answer the following questions as completely as you can. Use the assistance of a bed partner or other observer of your sleep if available. If the patient's and the observer's answers do not agree, include **BOTH** answers and indicate which answer is which. When "night" is mentioned, it means your longest, regular period of sleep. When "day" is mentioned, it means the rest of the time. All sensitive information is confidential, and not accessible as part of your medical record without your consent. This is an extensive and detailed questionnaire. It is important to fill it out carefully to ensure you get the proper evaluation and treatment.

Name _____ Date _____

Street Address _____

City _____ State _____ Zip _____

Home Phone (____)_____ Office Phone (____)_____ Ext. _____

Occupation _____ Social Security Number _____

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____ How Long? _____

Birthdate _____ Age _____ Sex _____ Height _____ Weight _____

Your Weight: 1 year ago? _____ 5 years ago? _____ 10 years ago?_____

Referred by _____ Group Name _____

Office phone (____) _____ Specialty _____

Who is your primary physician? _____ Group Name _____

Address _____ Phone (____) _____

How did you hear about our clinic? _____

Please describe your sleep problem. If you don't think you have a sleep problem, please tell us why you have come to the Sleep Center for an evaluation.

_____
_____
_____
_____

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Name: _____Social security number: _____Date: _____

Spouse or Emergency Contact(s): _____

Send copy of results to (e.g., family physician, internist): _____
(Please give name and address/tel no if known: _____

CHIEF COMPLAINT

Check any of the following that apply:
____Loud snoring
____Breathing or snoring stops for brief periods in my sleep
____Awaken gasping for breath
____Do not feel restored when I awaken
____Become sleepy during the day (please circle any/all that apply)
____sitting ____talking
____riding ____eating
____driving ____standing
____Difficulty falling asleep
____Difficulty remaining asleep
____Awaken too early

My MAIN sleep problem has bothered me:
[ ] 1 to 2 years
[ ] longer than 2 years
[ ] several months to 12 months
[ ] within the last 3 months
[ ] within the last month

SLEEP TREATMENT

I was previously diagnosed with:
___Sleep apnea When? _____ Where? _____

My prior treatment included:
____CPAP or BiPAP or Bilevel
Indicate treatment level (if known)_____
____Oral appliance
____Sinus, deviated septum or turbinate reduction
____Uvulopalatopharyngoplasty
____Laser or other procedure on uvula
____Mandibular surgery
____Tonsils and/or adenoidectomy

___Restless legs syndrome
When? _____ Where? _____ Treatment: _____

___Periodic limb movements
When? _____ Where? _____ Treatment: _____

___Narcolepsy
When? _____ Where? _____ Treatment: _____

___Insomnia
When? _____ Where? _____ Treatment: _____

SYMPTOMS DURING SLEEP

Indicate ON AVERAGE how often you experience the following symptoms especially when sleeping or trying to sleep:

Times per week

None	1-3	4-6	Daily	Symptom
				My mind races with many thoughts when I try to fall asleep
				I often worry whether or not I will be able to fall asleep
				Fatigue
				Anxiety
				Memory impairment
				Inability to concentrate
				Irritability
				Depression
				Awaken with a dry mouth
				Morning headaches
				Pain which delays or prevents my sleep
				Pain which awakens me from sleep
				Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up
				Inability to move as you are trying to go to sleep or wake up
				Sudden weakness or feel your body go limp when you are angry or excited
				Irresistible urge to move legs or arms
				Creeping or crawling sensation in your legs before falling asleep
				Legs or arms jerking during sleep
				Sleep talking
				Sleep walking
				Nightmares
				Fall out of bed
				Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
				Bed wetting
				Frequent urination disrupting sleep
				Teeth grinding
				Wheezing or cough disrupting sleep
				Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
				Shortness of breath disrupting sleep

SLEEP HABITS

Please answer the following questions as accurately as possible. Indicate AM and PM. If your work and/or sleep schedule changes during the week then indicate your schedule using the "shift work" column.

Activity	Usual schedule	Weekends	Shift Work
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you awaken each night?			
Number of times you have difficulty returning to sleep			
The total time I spend awake in bed			
I usually wake up from sleep at			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
Do you take naps and, if so, for how long?			
Begin work time			
End work time			

If you do rotating shift work, or have other work schedule changes and need more space to describe:

_____

_____

MEDICAL HISTORY

Please check if you have had any of the following:

( ) Heart disease List type: (e.g., CHF)_____ ( ) Diabetes ( ) Depression
( ) High blood pressure ( ) Asthma/Emphysema ( ) Reflux ( ) Thyroid condition
( ) Fibromyalgia ( ) Anxiety ( ) Seizures ( ) Parkinson's disease
( ) Stroke ( ) Head Injury or brain surgery

( )Pain which disrupts sleep. The typical location(s) for this pain is/are:
___Headaches ___Neck ___Back ___Chest ___Limb (arm(s) or leg(s))
___Abdominal ___Pelvic ___Joint (arthritis)

( )Other medical problems which may affect sleep (please list):_____

WEIGHT

What is your weight? _____ 1 year ago _____ 5 years ago _____
What is your collar size? _____ 1 year ago _____ 5 years ago _____

MEDICATION

Do you take anything to help you sleep? Y/N What?_____ How often?_____

List current medications and dosages, including both prescriptions and over-the-counter medications:

_____

_____

Are you on supplemental oxygen? Yes____ No ____ If yes, how much? _____(Liters/min)

SOCIAL HISTORY

Do you smoke? _____ Did you previously smoke? _____
How many years of smoking? _____ How much per day? _____
Do you drink alcohol? _____ How much? _____ drinks per (day/week/month) (please circle)
How much caffeinated coffee, tea or cola do you drink daily? _____
What do you usually do at work? _____

ENVIRONMENT

Is your bedroom (loud/quiet) and (light/dark)? (please circle)
Is your mattress (soft/hard/just right)? (please circle)
Do you go to sleep with the television on? Yes ___ No ___
Is your sleep disturbed because of your bed partner or others in your household (children or pets)? Yes ___ No ___

FAMILY HISTORY (Please check all that apply)

Is there a family history of:	Apnea	Snoring	Narcolepsy	Insomnia	Restless Legs Syndrome	Other sleep disturbances
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparent(s)						

Any other comments/ notes you would like to make: