Insomnia Evaluation Documentation

Date: _____

Patient Name: _____

Patient ID: _____

Referring Provider:

Name: _____

Contact Information: _____

Reason for Evaluation:

The patient is being referred for evaluation of insomnia, characterized by difficulty falling asleep and/or maintaining sleep over the past _____ (duration).

Medical History:

Previous medical conditions: _____

Current medications: _____

Sleep History:

- Average Sleep Duration: _____
- Sleep Onset Latency: _____
- Nocturnal Awakenings: _____
- Wake After Sleep Onset: _____
- Daytime Symptoms: _____

Clinical Assessment:

The patient demonstrates the following symptoms: _____.

Recommendations:

1. Sleep Hygiene Education

2. Cognitive Behavioral Therapy for Insomnia (CBT-I)

3. Follow-up appointment scheduled for _____.

Signatory:

Provider Name: _____

Signature: _____