SEARCY SLEEP AND MENTAL HEALTH

916 A East Race Ave.
Searcy, AR 72143

From Heber Springs/Pangburn: Take Hwy 16 into Searcy. At the curve, it turns into Race St. Go down Race St. and through the stoplight in front of Subway. Subway should be on your left. We are the 4th house past Subway, on the left. It is a gray/blue color. The big sign says Searcy Hometown Realty.

From Rosebud Area: Take Hwy 36 to Searcy. After it turns into Beebe Capps, turn left onto Main Street. Go all the way to the stoplight at Walgreens and take a right onto Race Street. Continue down Race and through the stoplight in front of Subway. Subway should be on your left. We are the 4th house past Subway, on the left. It is a gray/blue color. The big sign says Searcy Hometown Realty.

From Beebe/South 167: Take Hwy 167 to first Searcy exit. Follow Main Street until you reach the stoplight in front of Walgreens. Take a right onto Race Street. Continue down Race and through the stoplight in front of Subway. Subway should be on your left. We are the 4th house past Subway, on the left. It is a gray/blue color. The big sign says Searcy Hometown Realty.

From Kensett/Judsonia/Bald Knob/North 167: Hwy 167 to first Searcy exit. Follow East Race street towards downtown. You will pass Berryhill Park and Kroger. As you approach downtown, you will see Bison Crossing apartments on your right (gray apartments) and Harding college will be on your left. Once you pass the apartments, you will see Lindsey Plumbing- we are right next door to them. On the right. A gray/blue colored house. The big sign says Searcy Hometown Realty.

CANCELLATION AND NO-SHOW POLICY FOR SLEEP STUDY

We, at Sleep Centers of Arkansas, understand that sometimes you need to cancel/reschedule your appointment due to unforeseen circumstances. Therefore, we request that if you are unable to keep your appointment, you inform us prior to 24-hours before your appointment time or a rescheduling fee of **$200.00** will be charged to you. Once the appointment is kept, the deposit will be refunded. We understand that at times a 24-hour notice is not possible, and for this reason, the fee may be waived with approval. Each time a patient misses an appointment without giving proper notice, another patient is prevented from receiving care. This will ensure that each patient, including you, receives timely service.

Additionally, in order for each patient to get the necessary time attention, we ask that each patient arrive 10 minutes before their scheduled time. As a courtesy, an appointment reminder call/attempt will be made 1 business day prior to your appointment to assist you in these matters.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice of our policy and understand this policy.

______________________________ Name Printed

______________________ Date

______________________________ Signature

Sleep Centers of Arkansas
Intake Form

Patient Name:___________________________________Telephone:_______________________

Address: ____

City, State, & Zip Code:____

Social Security Number: ___________________Date of Birth: ____/____/____ ☐Male ☐Female

Marital Status:______________________ Telephone : _________________________________

Spouse/Parent:____________________ Medication Allergies:______________________________

Primary Care Doctor:_______________________ Referring Physician_______________________

Employer: ____________________________________ Address: _____________________________________ City, State, & Zip Code: _________________________ Telephone Number: ____________________________	ER Contact: ________________________ Relationship:________________________ Telephone Number: ________________

Primary Insurance:____ Insured's Name: ___________________________ Relation: ________________________________ Group Number: ____________________________Policy Number: __________________________ Telephone Number:_________________________Co-pay:__________________________________
Secondary Insurance: ____ Telephone Number: ____________________________________ Insured's Name: _______________________________ Relation: ___________________________ Group Number: ________________________________Policy Number: ______________________

I give Sleep Centers of Arkansas-Searcy my permission to leave voicemail messages at my phone number with information such as appointment times, test results and medication refills.

I exclude the following person(s) from these privileges: __________________________________

Signature:____ Date:_________________

New Patient Questionnaire

Name____Date of Birth:_______________
Height_____________________ Weight______________________
Collar Size_____________
Primary Care Physician____
What is your main problem while trying to sleep? ____
____
What is your normal bedtime? ______________What is your normal rise time? ______________
Do you use an alarm clock to wake up in the morning?____________________________________
How long does it take to go to sleep? ____
Do you take naps? Yes No If so, how long do they usually last?___________________________
How much sleep do you feel you get at night? ____
How many times do you feel you awake during the night? _________________________________

Do you feel rested in the morning? Yes No
Does your spouse complain that you disturb them at night? Yes No
Has anyone in your family been diagnosed with a sleep disorder? Yes No
Have you previously been diagnosed with a sleeping disorder? Yes No
If so, when, where and by whom? ____
____

Who lives in your household?____
What kind of work do you do and what are your typical work
hours:____

Please circle one:

Do you snore?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you cough at night?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you have morning headaches?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you have night sweats?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you have nightmares?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you sleep walk?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you sleep talk?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you feel weak when you get emotional?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Are you short-tempered?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you have trouble concentrating?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Does pain keep you awake?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do your legs feel restless at night?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do your legs ache or hurt at night?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do your legs jerk at night?	**Never**	**Rarely**	**Sometimes**	**Frequently**
Do you fall asleep at inappropriate times?	**Never**	**Rarely**	**Sometimes**	**Frequently**

Do you drink alcoholic beverages? Yes No

If so, how often? _____________ How much? ___________________

Do you drink beverages that contain caffeine (coffee, tea, soda, Mt. Dew)? Yes No

If so, how often? _____________ How much? ___________________

Have you ever smoked? Yes No

If so, how long? _____________ Packs per day? _________________

Do you have a family history of

High Blood Pressure?	No	Yes	Who?____
Heart Disease?	No	Yes	Who?____
Lung Disease?	No	Yes	Who?____
Stroke?	No	Yes	Who?____
Cancer ?	No	Yes	Who?____

Please check the following that you may have been diagnosed with or experienced:

___ Migraines	___ Weight Gain	___ Diabetes
___ Heart Disease	___ Memory Loss	___ Arthritis
___ Lung Disease	___ Fibromyalgia	___ Cancer
___ Neck/Back Pain	___ Asthma	___ Weight Loss
___ Gastric Reflux	___ Sinus Problems	___ High Blood Pressure
___ Loss of Energy	___ Nervousness	___ Depression
___ Thyroid Problems	___ Stroke or Mini-Stroke	___ Seizures
___ Kidney Problems	___ Blood clot in Leg/Lung	___ Exposed to TB

Other health problems?

____

____

Please list any surgeries that you have had in the past.

____

____

Have you taken medications to help you sleep? Yes No

If so, what and how often? ____

Drug Allergies:____

List all your current medications (if you have a written list, we will be glad to copy it for you):

Medication	Dosage:
_________________________	_____________________
_________________________	_____________________
_________________________	_____________________
_________________________	_____________________
_________________________	_____________________
_________________________	_____________________
_________________________	_____________________
_________________________	_____________________

How likely are you to doze off or fall asleep when placed in the following situations, opposed to just becoming tired?

Sitting and watching TV
0= Never Doze
1= Slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

Sitting and reading
0= Never Doze
1= Slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

Sitting inactive in a public place, such as a theatre, a meeting, or in church
0= Never Doze
1= Slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

Riding in a car for an hour without stopping as a **passenger**
0= Never Doze
1= Slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

Lying down to rest in the afternoon
0= Never Doze
1= Slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

Sitting quietly after lunch without alcohol
0= Never Doze
1= Slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

Sitting and talking to someone
0= Never Doze
1= Slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

In a car, stopped in traffic
0= Never Doze
1= Slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

Health Status Questionnaire

This survey asks about your views of your health. With this information, we will track how you feel and how well you are able to do your normal activities.

Name:_____________________________________ Date:___________________________

1. In general, would you say that your health is: 5 Excellent 4 Very Good 3 Good 2 Fair 1 Poor

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The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited a lot	Yes, Limited a little	No, Not at all
2. Early Morning activities?	1	3	5
3. Enjoy watching a movie w/ family?	1	3	5
4. Enjoy conversation during a car ride?	1	3	5

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5. During the past 4 weeks how much of the time did your physical health keep you from getting as much done at work , school or at home?

5 None 4 Slightly 3 Some 2 Quite a bit 1 Could not work

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6. During the past 4 weeks have you accomplished less than you would like to because of emotional problems? (such as depression or anxiety)

5 None 4 Slightly 3 Moderately 2 Quite a bit 1 Extremely

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7. During the past 4 weeks has your emotional and physical problems interfered with your activities with friends and family?

5 None 4 Slightly 3 Moderately 2 Quite a bit 1 Extremely

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8. How much bodily pain have you had during the past 4 weeks?

5 None 4 Mild 3 Moderate 2 Severe 1 Very Severe

In the last 4 weeks:	All the Time	Most the Time	Some of the Time	A little of the Time	None of the time
9. Have you felt calm?	5	4	3	2	1
10. Lots of Energy?	5	4	3	2	1
11. Have you felt blue?	1	2	3	4	5
12. Have you been happy?	5	4	3	2	1

Total Score: ____________