Initial Interview Record

Date: _____

Patient Surname: _____ First Name: _____

Referred by: _____

Presenting Symptoms:

_____

_____

_____

_____

_____

_____

Probable Causes:

_____

_____

_____

_____

_____

_____

Significant Health History:

_____

_____

_____

_____

_____

_____

Initials

_____

Psychological/Neurological:

Sleep problems? _____

Trouble falling asleep? _____

Frequent waking during night? _____

Abuse? _____

Social:

Smoke? _____

Alcohol intake? _____

Caffeinated beverages? _____

Recreational drugs? _____

Medications:

Prescription medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Non- prescription medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Recommendations:

_____

_____

_____

_____

Initials

_____