Shift Work Sleep Disorder Intake Form

Full Name

Date of Birth

Phone Number

Email Address

Occupation

Employer

Type of Shift Work

Describe your current shift schedule (hours, days, rotation)

How long have you experienced sleep difficulties?

What sleep difficulties do you experience?

How does your shift work affect your sleep and daily functioning?

List current medications, supplements, or substances used to aid sleep or wakefulness

Previous treatments or strategies attempted

Relevant medical or psychiatric history