

BOULDER CENTER FOR COGNITIVE AND BEHAVIORAL THERAPIES, LLP

Alisha Brosse, Ph.D.  
720/252-0611

Colleen Ehrnstrom, Ph.D.  
303/579-3245

---

GENERAL INFORMATION & REGISTRATION INSTRUCTIONS

Thank you for registering with the Boulder Center for Cognitive and Behavioral Therapies, LLP (BCCBT). We are pleased to be offering this service to you. Please read the following instructions carefully.

Please make checks and money orders payable to **BCCBT**. If you choose to pay via credit card on our website, you still need to complete this registration form. You will not be registered until we receive both the form and your payment. (Please note: there is a transaction fee for paying via credit card. This fee is included in the payment option on our website.)

Refunds: refunds (less a \$20 processing charge and less the credit card transaction fee if you used your credit card) will be provided if we receive a written request at least 7 days prior to the first day or actual day of event. No refunds will be given after this date, although you can apply lost funds to registration for a future half day intensive or group.

The registration process:

1. Complete the attached "Registration and Information Form"
2. Mail the last 2 pages of this form, along with your check or money order (made payable to BCCBT) to:  
Boulder Center for Cognitive and Behavioral Therapies  
ATTN: Sleep Therapies  
3020 Carbon Place, Suite 200  
Boulder, CO, 80301

Note: If you choose to pay on-line, please still complete the form and mail it immediately.

3. You will receive a confirmation letter, e-mail or phone call, with specific instructions.

Thank you again.

The Boulder Center for Cognitive and Behavioral Therapies, LLP

BOULDER CENTER FOR COGNITIVE AND BEHAVIORAL THERAPIES, LLP

COGNITIVE BEHAVIORAL THERAPY FOR INSOMNIA:  
REGISTRATION & INFORMATION FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Address: \_\_\_\_\_ Gender: \_\_\_\_\_  
\_\_\_\_\_

Phone 1: \_\_\_\_\_ Is it okay to leave a message? YES NO  
Phone 2: \_\_\_\_\_ Is it okay to leave a message? YES NO

EVENT YOU ARE REGISTERING FOR:

**CBT for Insomnia: A Half Day Intensive:**

Date of Intensive Seminar \_\_\_\_\_

Payment Enclosed: \_\_\_\_\_ \$140 full fee  
\_\_\_\_\_ \$120 early registration fee (postmarked 21 days prior)  
\_\_\_\_\_ \$100 "slumber party" fee (register with a friend at least 21 days prior)  
[Write friend's name here: \_\_\_\_\_ ]  
\_\_\_\_\_ I am paying by credit card

Please indicate if you would like to receive the assessment battery and driving directions by:  
\_\_\_\_\_ downloading the materials from our website (Please provide email on second page),  
OR  
\_\_\_\_\_ having them mailed to you

**Group CBT for Insomnia:**

Date of first group meeting \_\_\_\_\_

Payment Enclosed: \_\_\_\_\_ \$300 full fee  
\_\_\_\_\_ \$270 early registration fee (postmarked 21 days prior)  
\_\_\_\_\_ I am paying by credit card

How did you hear about this event? \_\_\_\_\_

What would you ideally like to get out of this event? (what are your goals/objectives)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

BOULDER CENTER FOR COGNITIVE AND BEHAVIORAL THERAPIES, LLP

*Providing the following information will allow us to better tailor our services for you. However, none of this information is mandatory – please leave blank any question that you are uncomfortable answering. Your responses will remain confidential.*

How long have you been experiencing sleep problems? \_\_\_\_\_

Please describe in your own words your sleep problems:

---

---

---

Which of the following do you experience on a regular basis? (Check all that apply.)

- Trouble falling asleep
- Trouble staying asleep during the night (multiple awakenings)
- Wake too early and can't fall back to sleep
- Non-restorative sleep (get enough hours of sleep but don't feel rested)
- Worry or anxiety *about your sleep*
- Fatigue or excessive sleepiness during the day
- Trouble with memory or concentration due to sleep deprivation

Which of the following assessments/treatments have you tried? (Check all that apply.)

*Past*    *Currently*

- Sleep Study
- CPAP/BiPAP breathing machine
- Prescription medications
- Over-the-counter sleep aids
- Sleep Hygiene strategies
- Sleep Restriction program
- Psychotherapy/counseling (specifically for help with sleep/fatigue)

Current Medications (name and dosage of all – not just sleep-related – prescription medications, over-the-counter medications and herbal remedies/supplements):

---

---

List/describe any current/chronic medical issues (e.g., diabetes; chronic back pain; thyroid disorder): \_\_\_\_\_

---

List/describe any current/chronic psychiatric disorders with which you've been diagnosed (e.g., depression, bipolar disorder, panic disorder, PTSD, social anxiety, alcohol/drug dependence):

---

---

BOULDER CENTER FOR COGNITIVE AND BEHAVIORAL THERAPIES, LLP

If you would like us to EMAIL your confirmation letter, please CLEARLY PRINT your email address here: \_\_\_\_\_

Please note that we do NOT consider email to be secure communication and we strongly discourage you from using email to communicate with us about clinically sensitive information.

The confirmation letter states that you've registered for a BCCBT event, gives information about the time and location of the event, and gives instructions for accessing the assessment battery and directions from our website, when necessary. We are happy to mail this letter if you prefer not to receive it via email – simply don't provide an email address.

Thank you!

Please mail the last three pages of this registration form and your payment (made payable to BCCBT) to:

Boulder Center for Cognitive and Behavioral Therapies  
ATTN: Sleep Clinic  
3020 Carbon Place, Suite 200  
Boulder, CO 80301