

## BOULDER CENTER FOR COGNITIVE AND BEHAVIORAL THERAPIES, LLP

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### SLEEP CLINIC: GENERAL INFORMATION & REGISTRATION INSTRUCTIONS

Our “Sleep Clinic” is a 4.5-hour workshop for adults who want to improve the quality and increase the amount of sleep they get each night. It is appropriate for individuals with a long history of sleep problems, and for those with a more recent onset. It is also appropriate both for people who suffer from sleep problems alone, and for those who have sleep disturbance in the context of another disorder (such as depression, bipolar disorder, chronic pain, or anxiety).

Participants will learn about:

- Various forms of sleep disturbances, as well as the basics of “normal” sleep
- Factors that cause and maintain sleep disorders
- Research-based cognitive-behavioral techniques that improve sleep
- How to tailor the information to create a personalized program

The fee includes:

- Information provided by licensed clinical psychologists in a lecture format
- Copy of lecture notes, list of recommended readings and local resources, and handouts for designing a personalized program
- Question and answer session
- A small-group format (maximum enrollment = 15)

Fee: \$120, with a \$20 discount if your registration is postmarked (or if you pay via website) at least *14 days* before the Clinic. Make it a “slumber party” – *register with a friend* (at least 10 days prior to the clinic) and pay only \$90/person! Please make checks and money orders payable to **BCCBT**.

Refunds: refunds (less a \$20 processing charge) will be provided if we receive a written request at least 7 days prior to the Clinic. No refunds will be given after this date, although you can apply lost funds to registration for a future clinic.

The registration process:

1. We *strongly* encourage participants to complete a pre-clinic assessment battery, including a 1-week sleep log, AND we would very much like to review the assessments before the Clinic. To facilitate this, we recommend that you *register as soon as possible*, and that you opt to *download the assessment battery* from our website if you have access to the web and a printer.
2. Complete the attached “Registration and Information Form”
3. Mail the form and your check or money order (made payable to BCCBT) to Boulder Center for Cognitive and Behavioral Therapies, ATTN: Sleep Clinic, 3393 Iris Avenue, Suite 206, Boulder, CO, 80301. (Note: We hope to accept credit cards via on-line registration in the near future; visit [bouldercbt.com/sleep-clinic.shtml](http://bouldercbt.com/sleep-clinic.shtml) to see if this option is currently available. If it is and you choose to pay on-line, please still complete the form and mail it immediately.)
4. You will receive a confirmation letter, e-mail or phone call. If you have opted to download the battery from our website, we will provide you with the necessary password.

Please keep these instructions for future reference.

SLEEP CLINIC: 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

Sleep Clinic date for which you are registering: \_\_\_\_\_

Payment Enclosed: \_\_\_ \$120 full fee

\_\_\_ \$100 early registration fee (postmarked 14 days prior)

\_\_\_ \$90 "slumber party" fee (register with a friend at least 10 days prior)

[Write friend's name here: \_\_\_\_\_ ]

Please indicate if you would like to receive the assessment battery and driving directions by:

\_\_\_ downloading the materials from our website, OR

\_\_\_ having them mailed to you

How did you hear about the Sleep Clinic? \_\_\_\_\_

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

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

*Providing the following information will allow us to better tailor the Sleep Clinic to our audience. 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

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assessments/treatments have you tried? (Check all that apply.)

| <i>Past</i> | <i>Currently</i> |   |
|-------------|------------------|---|
| _____       | _____            | 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):

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

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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):

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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 "Sleep Clinic," gives information about the time and location of the Clinic, and gives instructions for accessing the assessment battery and directions from our website. 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 both pages of the registration form and your payment (made payable to BCCBT) to:

Boulder Center for Cognitive and Behavioral Therapies  
ATTN: Sleep Clinic  
2501 Walnut Street, Suite 108  
Boulder, CO 80302