

Our Physicians:

Michael L. Cohen, M.D.  
Harry J. MacDannald, M.D.  
Karin Cheung, M.D.  
Fred Nachtwey, M.D.  
David Safianoff, M.D.  
Peter Chase, D.D.S., M.A.



TEL: (925) 935-7667 FAX: (925) 945-7667

Website: [www.ccsleepcenter.com](http://www.ccsleepcenter.com)

Email: [info@ccsleepcenter.com](mailto:info@ccsleepcenter.com)

Our Locations:

(main location)  
1700 Ygnacio Valley Rd, Ste 100  
Walnut Creek, CA 94598  
(satellite location)  
350 John Muir Pkwy, Ste 175  
Brentwood, CA 94513

**PATIENT INFORMATION PACKET**

Patient Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Day/Date of Study: \_\_\_\_\_ Time of Arrival: \_\_\_\_\_

**If unable to keep this appointment please notify us AT LEAST 24 hours in advance, otherwise there is \$100 Cancellation fee. Thank you.**

**GENERAL INFORMATION**

**Prior to your study, please:**

1. Do not take any naps during the day of your study.
2. Limit caffeinated beverages within 8 hours of your study.
3. Unless otherwise instructed, take your medications as prescribed by your physician.
4. Shower and wash your hair the day of your sleep study. Do not use hair sprays or gels. *If you have hair extensions or a hairpiece, they will need to be removed prior to your study as they can interfere with electrode placement.*
5. Bring something comfortable to sleep in and any toiletries you require.
6. Completely fill out the enclosed questionnaire(s) and give them to your technician upon arrival for your sleep study.

**Also:** \*You may bring your own pillow, a robe, and reading material, if desired. Your room will have cable TV in it.

\*Additional information is available through our website: [www.ccsleepcenter.com](http://www.ccsleepcenter.com), or our automated information system at (925) 935-7667. Normal business office hours are Monday-Friday from 9am-5pm.

**What you should expect when having your sleep study performed:**

During a diagnostic sleep study, many types of data are recorded. The Sleep Technologist will place electrodes on your skin to monitor brain waves, eye movements, certain muscle activities and heartbeat. A small sensor will be applied near your nose and mouth to monitor airflow. Respiratory effort belts will be attached around your chest and abdomen. An Oximeter sensor will be taped onto one of your fingers to measure blood oxygen saturations levels. These monitoring devices are used to ensure an accurate evaluation of your sleep. The wires will be bundled enabling freedom of movement. Your movement will not be restrained; so, for example, if you need to go to the restroom or reach for a glass of water, you will be free to do so.

During the study, the technologist will monitor your sleep and will also be available to assist you in any way should you require help. In the morning, the technologist will remove the electrodes and equipment. Later, a Sleep Technologist will review (hand-score) your study, page-by-page, and then send the results to an interpreting physician. The final report will be provided to your physician. Results are generally ready 5-10 business days after your study is completed.

**DIRECTIONS TO BOTH OUR WALNUT CREEK & BRENTWOOD LOCATIONS ARE INCLUDED ON THIS PAGE**

**DIRECTIONS TO OUR WALNUT CREEK LOCATION**

**1700 YGNACIO VALLEY RD, STE 100, WALNUT CREEK, CA 94598**

We are located in the **Park Professional Building** directly in front of Heather Farms Park in Walnut Creek; just one block down from John Muir Medical Center. Our building is located in between **Valley Veterinary Hospital** and **St. John Vianney Catholic Church**.

**Driving South on 680**

Take the North Main Street off-ramp and proceed South to Ygnacio Valley Rd. Make Left onto Ygnacio Valley Rd and proceed to San Carlos Drive (**you'll see a shell gas station on one corner and a Chevron gas station on the opposite corner**). Make a U-Turn at San Carlos Drive and go back one block to Marchbanks Dr. & make a right. Make immediate right into first driveway. We are located in the 1<sup>st</sup> building on the left (1700 Ygnacio Valley Rd, Ste 100) **There will be a red sign that reads "SLEEP" in the window.**

**Driving North on 680**

Take Ygnacio Valley Rd off-ramp. Make right onto Ygnacio Valley Rd. Proceed to San Carlos Dr. (**you'll see a shell gas station on one corner and a Chevron gas station on the opposite corner**) Make U-Turn at the light at San Carlos Dr and go back one block to Marchbanks Dr & make a right. Make immediate right into first driveway. We are located in the 1<sup>st</sup> building on the left (1700 Ygnacio Valley Rd, Ste 100). **There will be a red sign that reads "SLEEP" in the window.**

**Driving East on HWY 24**

Take Ygnacio Valley Rd off-ramp and make a Right onto Ygnacio Valley Rd. On Ygnacio Valley Rd proceed to San Carlos Dr, (**you'll see a shell gas station on one corner and a Chevron gas station on the opposite corner**), and make a U-Turn at the light at San Carlos Dr. Go back one block to Marchbanks Dr & make a right. Make an immediate right into first driveway. We are located in the 1<sup>st</sup> building on the left (1700 Ygnacio Valley Rd, Ste 100) **There will be a red sign that reads "SLEEP" in the window.**

**DIRECTIONS TO OUR BRENTWOOD LOCATION**

**350 JOHN MUIR PARKWAY, STE 175, BRENTWOOD, CA 94513**

We are located off Balfour Rd near HWY 4 Bypass on John Muir Parkway, on the opposite side of Balfour Rd from Fire Station 52 (Located at 201 John Muir Parkway). We are on the same side of Balfour Rd as the Arco gas station on the corner of Balfour and John Muir Parkway.

We are not located in the new John Muir Medical Center. We are in the Brentwood Medical Office Bldg located \_ mile down the road from the John Muir Medical Center. When entering the parking lot, drive the right rear of the building and look for a door marked with #175. There should be a lighted red sign in the window that reads "**SLEEP**".

**From Pittsburg Area towards Stockton**

Take Highway 4 East towards Stockton. Continue on HWY 4 Bypass Labeled "Bypass Brentwood" (Left lanes of freeway). Continue on Highway 4 Bypass. Make a right onto Balfour Rd. Make a left onto John Muir Parkway. Our Building will be on your left hand side.

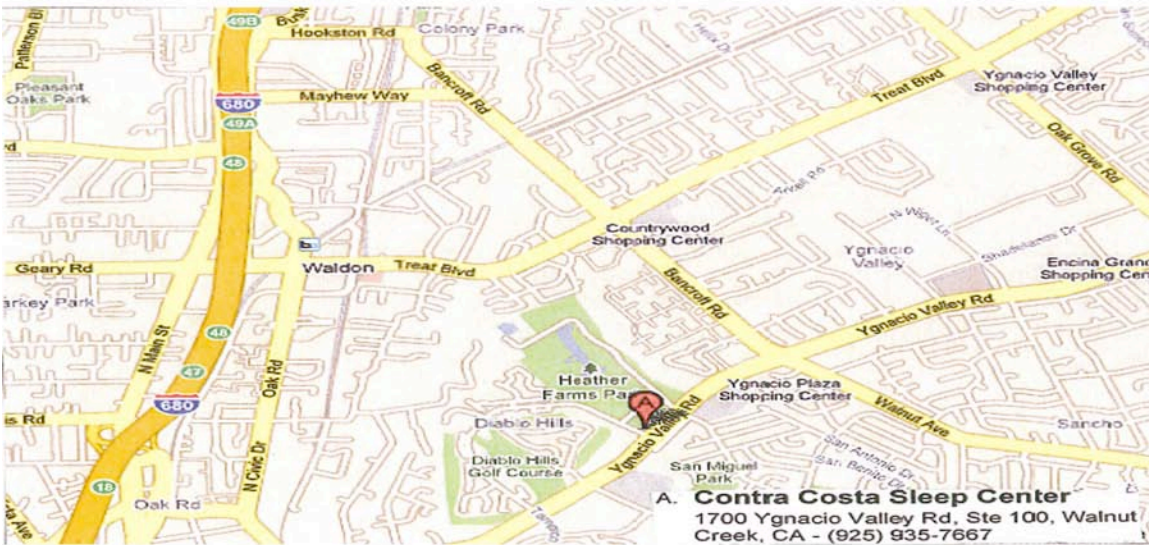
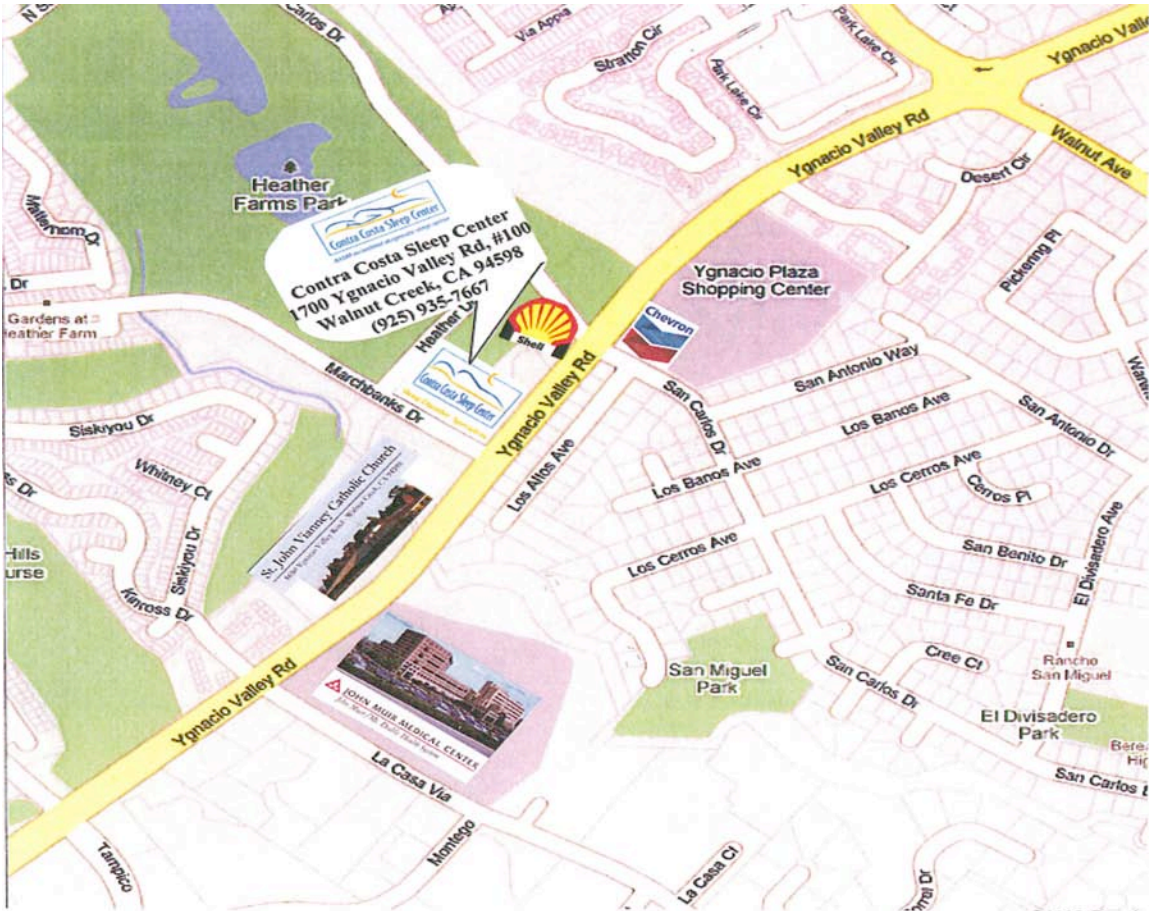
**From Stockton Area Towards Pittsburg**

Take Highway 4 West towards Pittsburg. Turn left onto Balfour Rd. Turn Left onto John Muir Parkway. Our building will be on your left hand side.

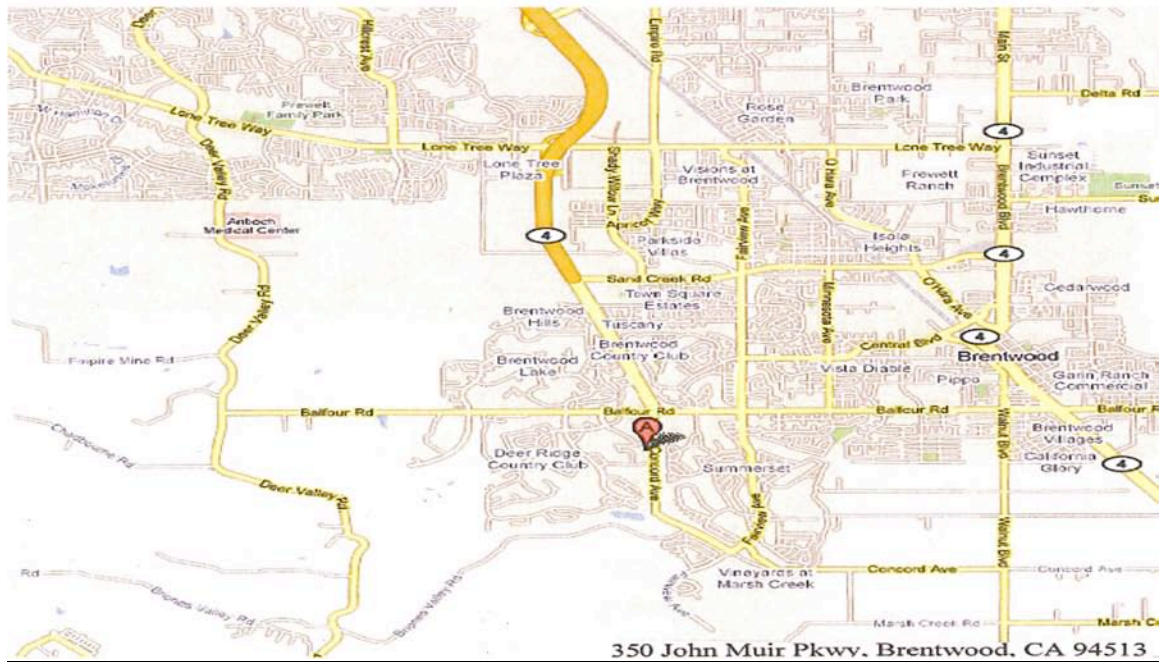
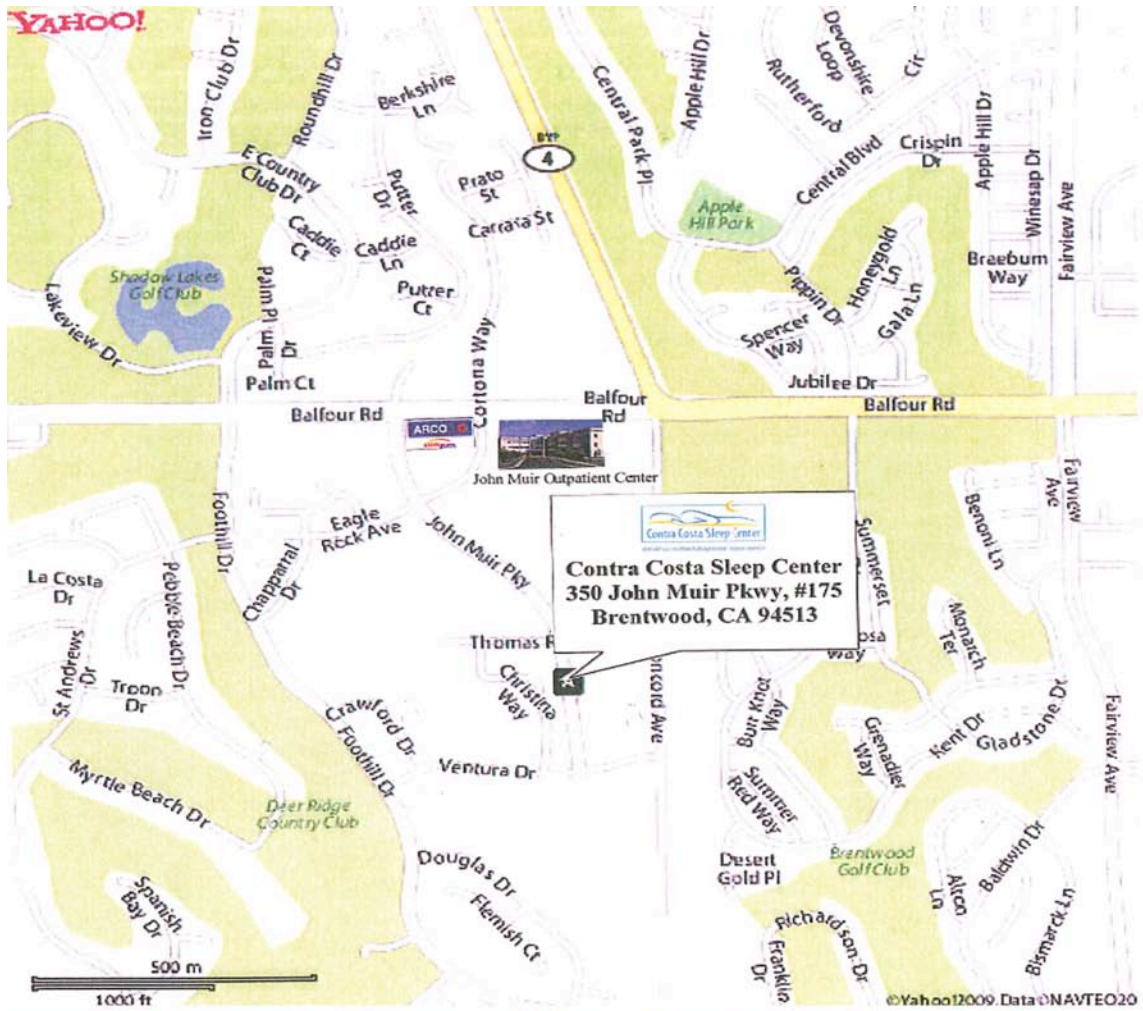
Park on the right, rear side of the building near the door for Suite 175. To enter sleep center, press the doorbell and the technician will be with you shortly.

**IF YOU HAVE ANY TROUBLE FINDING EITHER LOCATION, PLEASE CALL (925) 935-7667.**

**Map of Contra Costa Sleep Center in Walnut Creek**



**Map of Contra Costa Sleep Center in Brentwood**



## **FREQUENTLY ASKED QUESTIONS BY OUR SLEEP CENTER PATIENTS**

### **HOW LONG WILL THE STUDY LAST?**

-Ideally, we try to capture four to eight hours of sleep to assure a sufficient amount of data for analysis by the sleep disorders physicians.

### **AM I IN A ROOM BY MYSELF?**

-You have your own private room that has a queen size bed in it. A technician will be monitoring you throughout the night in a separate control room.

### **CAN A FAMILY MEMBER/FRIEND STAY WITH ME DURING THE STUDY?**

-This is a medical procedure so it is not recommended that a family member/friend stay the entire night with you unless there are special circumstances/needs. However, you can have someone stay with you during the set-up process if that would help you feel more comfortable. The set-up takes about an hour. If the patient is a minor, a parent is welcome to stay the night with their child.

### **HOW WILL I SLEEP WITH ALL OF THE EQUIPMENT ATTACHED TO ME? WON'T IT BE UNCOMFORTABLE?**

-At first glance, you may feel appropriately attired for a film of the science fiction genre, however your freedom of movement throughout the night will be largely unrestricted. As long as you are mindful of the sensors and move with care, there is no reason why you can't sleep in the position you find most comfortable. The technologist may ask you to roll to your side or back at some point to study sleep in all positions. Most of our patients experience only a minor change in their sleep quality.

### **WILL THE TECHNOLOGIST BE ABLE TO GIVE ME MY RESULTS IN THE MORNING?**

-The technologist's job is to record the highest quality information possible and to make you feel comfortable throughout the night. The overnight part of the study is really just the tip of the iceberg. Following the study, a thorough analysis and interpretation will be made by a qualified sleep disorders center physician, along with recommendations for future steps, if indicated. The results of your sleep study will be sent to your referring physician and to you if you so desire, within 5-10 working days after your study.

### **WILL THE PHYSICIAN CONTACT ME DIRECTLY WITH THE RESULTS?**

-If you were referred to the sleep center by your physician for a sleep study your doctor will receive the interpretation of your study and should contact you with your results.

### **I GET VERY THIRSTY DURING THE NIGHT, AND AWAKEN WITH A DRY MOUTH. CAN I KEEP SOME WATER AT THE BEDSIDE?**

-Yes. We do ask that patients refrain from any caffeinated beverages during the night, however, as they interfere with sleep.

### **I WAS GIVEN A BRIEF INTRODUCTION TO CPAP PRIOR TO MY STUDY AND VIEWED AN EDUCATIONAL VIDEO ON THIS SUBJECT-DOES THIS MEAN THAT CPAP WILL BE A DEFINITE PART OF MY STUDY?**

-Patients are given an introduction prior to the study (unless the referring physician has indicated otherwise) to prepare them in the event that CPAP is indicated. The first two hours of your study help to determine if criteria for a trial of CPAP are met. If sufficient sleep is acquired, and the criteria established by the physicians for a trial of CPAP are met, a trial will be initiated.

### **WHAT IF I NEED TO GET UP TO GO TO THE WASHROOM?**

-The technologist recording your sleep study will be in the lab area throughout the night. A camera will monitor you and your voice will be audible via intercom system for the duration of your study. Simply call the technologist, who will assist you in getting up and walking to the washroom. If you prefer not to walk to the washroom, urinals are always available. Let us know if you prefer a commode.

### **I WILL BE LEAVING FOR WORK FROM THE SLEEP CENTER IN THE MORNING FOLLOWING THE STUDY. WILL I BE ABLE TO GET TO WORK ON TIME?**

-Inform your technologist of any scheduling concerns before your study begins, and every attempt will be made to perform a complete study within those boundaries. Incidentally, bathing facilities are not located in the facility.

### **I USUALLY TAKE MEDICATION JUST BEFORE BEDTIME-SHOULD I AVOID TAKING IT ON THE NIGHT OF MY STUDY?**

-Unless your physician has specifically instructed you otherwise, you should continue to take your normal medications before bedtime. In performing the study, we try to adhere to your normal routine as closely as we can within lab protocols. Please do list your medications on the pre-sleep questionnaire that the technologist gives you.

### **WHO CAN I CONTACT IF I HAVE ADDITIONAL QUESTIONS OR CONCERNS REGARDING MY SLEEP STUDY?**

-Our office staff and chief technologist are available between 9:00am-5:00pm, Monday through Friday at (925) 935-7667 to answer your questions.

## WHAT IS SLEEP APNEA?

Sleep Apnea is a disorder that causes people to frequently stop breathing while sleeping. People who suffer from sleep apnea stop breathing many times during their sleep. As a result, they fail to get oxygen their body needs and a restful night's sleep.

### IS SLEEP APNEA A SERIOUS DISORDER?

Yes. If left untreated, sleep apnea increases your risk for heart problems and stroke. It can also lead to:

- Excessive daytime sleepiness
- Decreased performance at work
- Increased possibility of accidents while driving or operating heavy equipment
- Lack of concentration
- Impaired sexual function
- Memory loss

### WHAT CAUSES SLEEP APNEA?

Obstructive Sleep Apnea (OSA) is the most common form of the disorder. It is caused by structures in the throat blocking the flow of air in and out of the lungs during sleep.

Central Sleep Apnea (CSA) results from the brain not signaling you to breathe during sleep. In a sense, the brain "forgets" to breathe during sleep.

Mixed Sleep Apnea (MSA) is a combination of both OSA and CSA.

Many people who have sleep apnea don't even know they have it. Often a family member or bed partner will notice the signs of sleep apnea before you do.

### WHAT ARE THE SYMPTOMS OF SLEEP APNEA?

- Restless Sleep
- Morning Headaches
- Loss of Energy
- Irritability, short temper
- Anxiety or depression
- Falling asleep during the day at work, while watching TV, listening to lectures, reading
- Loud snoring interrupted by silence and then gasps
- Forgetfulness
- Falling asleep while driving
- Difficulty concentrating
- Mood or behavior changes
- Decreased interest in sex

### A SLEEP STUDY CAN TELL YOU WHETHER YOU HAVE SLEEP APNEA.

Talk to your doctor. If he or she suspects you have sleep apnea, you will be asked to have a sleep test to confirm this diagnosis. During a sleep test, you will be observed as you sleep. Specially trained technologists will record many kinds of data about your sleep and breathing problems. As a result of testing, you will find out whether or not you have sleep apnea. Testing can also tell what type of sleep apnea you have, and what kind of treatment will help you most.

### WHAT CAN BE DONE ABOUT SLEEP APNEA?

Sleep apnea is a correctable health problem. Not long ago, surgery was thought to be the best way to treat sleep apnea. In some cases surgery may still be necessary, but most patients can be treated successfully through other means of therapy.

One therapy relies on Continuous Positive Airway Pressure (CPAP)- which is the most prescribed treatment for sleep apnea. CPAP is delivered through a small amount of pressure, applied through a mask over the nose. This pressure prevents structures in your throat from blocking the air movement in and out of the lungs while you sleep. You will experience almost immediate relief from your symptoms by using CPAP therapy.

Discuss treatment options with your physician. With proper treatment, sleep apnea sufferers can lead normal lives.

### YOUR PHYSICIAN MAY ALSO SUGGEST THAT YOU:

- Lose weight
- Avoid alcohol, especially close to bedtime
- Take medications with caution, especially sleeping pills; some can depress breathing and can make sleep apnea worse.

CONTRA COSTA SLEEP CENTER (CCSC)

1700 Ygnacio Valley Rd, Ste 100, Walnut Creek, CA 94598

350 John Muir Parkway, Ste 175 Brentwood, CA 94513

**Patient Name:** \_\_\_\_\_  
(please print clearly)

**PATIENT AUTHORIZATION FOR SERVICES PROVIDED & PAYMENT AGREEMENT**

***I hereby authorize Contra Costa Sleep Center to release any and all of my medical records to my referring physician, as well as any other physicians noted below.***

**Referring Physician:** \_\_\_\_\_

**Other(s), please list phone #s if possible)** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***Insurance Coverage:***

Most insurance companies and other third-party payers of healthcare benefits will pay in whole or in part for the services and products ordered by your physician and provided by CCSC.

CCSC will contact your insurer to verify your coverage and obtain authorization to provide services to you and bill your insurance payer in the amounts they approve for payment. We will provide you with our findings upon your inquiry; however, CCSC is not responsible for the completeness and accuracy of your payer's information. We therefore strongly recommend that you also contact your insurer so that you have a complete understanding of the benefits your plan affords you.

Please further understand that the authorization we obtain is only valid through its date of expiration and provided that nothing in your benefits has changed, such as your policy being canceled or expired, pre-existing condition determination, or change in employer or primary care physician.

***Patient Payment:***

CCSC will bill your health benefits payer as a courtesy. Payment for services, equipment, products or supplies provided to you are your sole and exclusive responsibility. This amount may include any and all amounts denied or not reimbursed by your insurer, a co-pay or deductible as required by your benefits provider. Payment is due in full, paid to CCSC, no later than 30 days from the date on the CCSC statement sent to you.

Additionally, should your insurer pay you directly for the services provided by CCSC, you agree to reimburse CCSC in the same amount within 15 days from the date on the payment check, as well as any personally owed amounts in 30 days as noted above.

By signing below, I agree that I have read and understand the above, and also agree to personally pay directly to CCSC any and all amounts not paid for any reason by my insurer within 30 days of the date on the CCSC statement. I also authorize CCSC to release any information necessary to my health benefits payer to process my insurance claim(s).

**Responsible Party (if other than patient):** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Contra Costa Sleep Center**  
**PATIENT RIGHTS AND RESPONSIBILITIES**

***All patients shall have rights, which include, but are not limited to the following:***

- To be given a statement of services available by the agency and related charges.
- To have access to the services, regardless of race, religion, sex or source of payment.
- To have the right to request and receive an itemized and detailed explanation of the total bill for services rendered and products supplied.
- To have access to the physician directing his/her care and information regarding his/her diagnosis, treatment or prognosis.
- To be communicated to in a way that he/she can reasonable expect to understand.
- To be informed about the nature of any technical procedure that will be performed, as well as who will perform the procedure.
- To have the right to refuse treatment (as permitted by law) and be informed of the medical consequences of such refusal.
- To seek assistance in finding and transferring the provision of services to another agency.
- To receive care in a timely manner, appropriate to his/her needs.
- To be treated with consideration, respect and full recognition of his/her dignity, individuality, and privacy. To be assured of confidentiality in treatment and records of such and be allowed to approve or refuse their release to any outside agencies.
- To have competent and qualified personnel carry out the services for which they are responsible.
- To be provided access to the State Health Department for problems about services.
- To voice grievances and recommend changes in policies and services. The patient will be informed of Contra Costa Sleep Centers' mechanism of receiving and resolving patient complaints.
- To be allowed to have patients' family or guardian exercise the patients' rights when the patient has been judged incompetent.

***All patients shall have responsibilities, which include, but are not limited to the following:***

- To provide, to the best of his/her knowledge accurate and complete information about present medications and/or other matters relating to his/her healthcare.
- To report unexpected changes in his/her condition to those clinicians responsible for the management of his/her care.
- To make it known whether he/she clearly understands a contemplated course of action and what is expected of him/her.
- To follow the treatment plan recommended for his/her care by the primary care physician and other allied health professionals, including nurses, pharmacists, and dieticians.
- To keep appointments and, when unable to so for any reason, to notify Contra Costa Sleep Center **NO LATER THAN 24 HOURS** prior to the scheduled appointment; **otherwise there will be \$100 Cancellation fee.**
- To assume responsibility for his/her actions if he/she refuses treatment or does not follow the instructions as set forth by his/her primary care physician and the professional staff of Contra Costa Sleep Center.
- To assure that the financial obligations of his/her health care are fulfilled as promptly as possible.
- To be considerate of the rights of Contra Costa Sleep Center personnel and representatives.
- To be respectful of the property of Contra Costa Sleep Center and its personnel.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**CONTRA COSTA SLEEP CENTER  
GENERAL HEALTH QUESTIONNAIRE**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(please print clearly)

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Please answer the following questions regarding your general health.  
Please *circle* the appropriate answer.**

Do you have high blood pressure?	Yes	No
Have you experienced a heart attack?	Yes	No
Do you have a history of irregular heartbeats?	Yes	No
Have you experienced chest pain?	Yes	No
Have you had prior heart surgery?	Yes	No

**Do you have a history of the following disorders?**

Asthma	Yes	No
Bronchitis	Yes	No
Chronic Obstructive Pulmonary Disease (COPD)	Yes	No
Emphysema	Yes	No
Tuberculosis Exposure	Yes	No
Diabetes	Yes	No
Stroke	Yes	No
Congestive Heart Failure	Yes	No
Hepatitis (List type: _____)	Yes	No

**Please list any other medical history/conditions below:**

---

---

---

**Are you having this sleep study post surgery?**      **Yes**      **No**

**If yes, when did you have surgery** \_\_\_\_\_

**What type of surgery** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**CONTRA COSTA SLEEP CENTER**

**INSTRUCTIONS**

- 1. Please print clearly and complete all information
- 2. Please furnish a copy of your insurance card (front & back)

**PATIENT TO COMPLETE**

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS (NUMBER, STREET)	CITY	STATE ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	DATE OF BIRTH(MM/DD/YY)
SEX: MALE FEMALE	SOCIAL SECURITY NUMBER	MARITAL STATUS M S W D DP
EMPLOYER	OCCUPATION	
EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER	
EMAIL ADDRESS		

**EMERGENCY/REFERRAL INFORMATION**

PRIMARY CARE PHYSICIAN	PCP PHONE NUMBER	PCP ADDRESS
REFERRING PHYSICIAN (IF DIFF THAN PCP)	REFERRING PHYSICIAN PHONE #	REFERRING PHYSICIAN ADDRESS
FAMILY MEMBER OR FRIEND	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
RELATIONSHIP TO PATIENT	ADDRESS	

**ELIGIBILITY GUARANTEE SECTION**

PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER
PRIMARY INSURANCE PHONE #	PRIMARY INSURANCE ADDRESS	
SUBSCRIBER (IF OTHER THAN PATIENT)	RELATIONSHIP TO PATIENT	
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SOCIAL SECURITY NUMBER	
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER
SECONDARY INSURANCE PHONE #	SECONDARY INSURANCE ADDRESS	
SUBSCRIBER (IF OTHER THAN PATIENT)	RELATIONSHIP TO PATIENT	
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SOCIAL SECURITY NUMBER	

I hereby authorize Contra Costa Sleep Center to contact my insurance company to verify my insurance coverage. I understand that if I am not eligible, I am liable for all charges rendered. I agree that if this information is not true, I (or the above person named financially responsible for me) will pay in full all such charges. I also authorize Contra Costa Sleep Center to release any medical information necessary to process my insurance claim. I hereby authorize payment of medical benefits directly to: CONTRA COSTA SLEEP CENTER.

1700 YGNACIO VALLEY RD, STE 100 Walnut Creek, CA 94598 Phone (925) 935-7667 Fax (925) 945-7667

SIGNATURE OF PATIENT

SIGNATURE OF INSURED

DATE SIGNED

<b>CONTRA COSTA SLEEP CENTER</b>
----------------------------------



**PRE-STUDY QUESTIONNAIRE FORM (Please fill out these questions on the day of your scheduled study)**

NAME: \_\_\_\_\_ STUDY DATE: \_\_\_\_\_

1. What time did you go to sleep last night? \_\_\_\_\_:\_\_\_\_\_AM/PM
2. Compared to usual, did you go to sleep last night: (Circle One) EARLIER SAME LATER
3. What time did you wake this morning? \_\_\_\_\_:\_\_\_\_\_AM/PM
4. Compared to usual, did you wake this morning: (Circle One) EARLIER SAME LATER
5. How many hours sleep did you get for the last two nights: LAST NIGHT \_\_\_\_\_Hours  
NIGHT BEFORE LAST \_\_\_\_\_Hours
6. Did you get enough sleep last night? Yes No
7. Have you had any alcoholic or caffeinated beverages today or tonight? Yes No  
If so, WHAT? \_\_\_\_\_ WHEN? \_\_\_\_\_
8. Do you usually have alcoholic or caffeinated beverages? Yes No
9. Did you take any naps today or tonight? Yes No  
If so, WHEN? \_\_\_\_\_
10. Do you usually take naps? Yes No
11. Have you felt ill today or tonight? Yes No
12. Do you usually sleep alone? Yes No

**ANSWER ALL QUESTIONS BELOW BY CIRCLING THE NUMBER FO THE BEST RESPONSE**

1 = NOT AT ALL

2 = SOMEWHAT

3 = VERY

- |  |   |   |   |
|--|---|---|---|
| 13. How physically tired do you feel right now?    | 1 | 2 | 3 |
| 14. How mentally tired do you feel right now?      | 1 | 2 | 3 |
| 15. How tense or anxious do you feel right now?    | 1 | 2 | 3 |
| 16. How depressed or "blue" do you feel right now? | 1 | 2 | 3 |
| 17. How sleepy do you feel right now?              | 1 | 2 | 3 |

Phone (925) 935-7667 \*\*\* Fax (925) 945-7667