LINCOLN BEHAVIORAL HEALTH CLINIC

3201 Pioneers Blvd., Lincoln, NE 68502 • 402-489-9959

PATIENT'S INFORMATION (please print clearly)

Today's Date:

Last Name First M.I. | Birthdate: | Sex: ☐ Male ☐ Female ☐ Other

Is this the patient's legal name? ☐ Yes ☐ No | If No, what is the patient's legal name? | Email address:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated | SSN:

Street Address:

City: State: Zip:

Home Phone: | Cell Phone: | Referral from:

May we leave message? ☐ Yes ☐ No

Do you consent to text and/or email communication? ☐ Yes ☐ No

Current Work Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Not Employed

Occupation: | Employer's Name and Address: | Work Phone & Ext:

Current School Status: ☐ Full Time ☐ Part Time | Name of School:

GUARANTOR/RESPONSIBLE PARTY (if not the client)

Name: | SSN: | Birthdate: | Relationship:

Billing Address: | City, State, Zip:

Home Phone: | Work Phone: | Cell Phone:

INSURANCECOVERAGE

Is this patient covered by insurance? ☐ Yes ☐ No

MEDICARE COVERAGE (specify)	MEDICAID COVERAGE (specify plan)
Is Medicare Primary? ☐ Yes ☐ No	Is this patient covered by Medicaid? ☐ Yes ☐ No
Medicare #:	Medicaid Plan #:
Railroad Medicare #:	Is this patient a Ward of the State: ☐ Yes ☐ No
Supplementary:	If yes-caseworker name/phone:
Plan Name:	
Plan #:	

PRIMARY INSURANCE COVERAGE

Insurance Company and Address: | Subscriber's Name: | Primary Insurance? ☐ Yes ☐ No

Subscriber's Address: | Subscriber's SSN: | Date of Birth: | Is this a Self/Individual Plan? ☐ Yes ☐ No

Policy #: | Group #: | Subscriber's Relationship to Patient: | Subscriber's Employer:

SECONDARY INSURANCE COVERAGE

Insurance Company and Address: | Subscriber's Name: | Primary Insurance? ☐ Yes ☐ No

Subscriber's Address: | Subscriber's SSN: | Date of Birth: | Is this a Self/Individual Plan? ☐ Yes ☐ No

Policy #: | Group #: | Subscriber's Relationship to Patient: | Subscriber's Employer:

Lincoln Behavioral Health Clinic

In your own words, please state why you have come to LBHC:

____

____

____

____

____

Please list any family mental health history:

____

____

____

____

____

____

List Child(ren), Siblings and/or Parents Living in the Home where client resides:

Name:	Relationship:	Age:

List Child(ren), Siblings and/or Parents Not Living in the Home:

Name:	Relationship:	Age:

If minor child, name of Legal Custodian: ________________________________

If minor child name of Physical Custodian: ________________________________

If applicable, school attending: ________________________________

Lincoln Behavioral Health Clinic

Client Name: ______________________________ **DOB:** __________

Primary Care Physician: _____________________ **Phone Number:** _____________

____**I DO** authorize Lincoln Behavioral Health Clinic to communicate with my Primary Care Physician regarding my care.

____ **I DO NOT** authorize Lincoln Behavioral Health Clinic to communicate with my Primary Care Physician regarding my care.

EMERGENCY CONTACT INFORMATION:

Name:______________________________ **Relationship:** ________________

Phone: ______________________________

Signature: _____________________________ **Date:** ____________

Do you have an Advanced Directive? YES NO (circle one)

Would you I like additional information or resources about Advanced Directives? YES NO (circle one)

***Advance directives are written instructions that express your wishes about the kinds of medical care you want to receive in an emergency. If you wish, we can put a copy of your advance directives into your medical file.*

Client Medication List

Prescription Medications:

____

____

____

____

____

____

Vitamins and Other Non-Prescription Drugs:

____

____

____

____

____

Signature: ______________________________

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ____________________ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**________

If this questionnaire is completed by an informant, **what is your relationship with the individual?** ____________
In a typical week, approximately how much time do you spend with the individual? ____________ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem   Minor Problem   Moderate Problem   Serious Problem

	YES	NO
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

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GAD-7 Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer")*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: ___ + ___ + ___ + ___

= ***Total Score*** _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

PHQ-9 Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer")*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things...............	0	1	2	3
2. Feeling down, depressed, or hopeless.................	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much..	0	1	2	3
4. Feeling tired or having little energy.......................	0	1	2	3
5. Poor appetite or overeating................................	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down......................	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television............................	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual..	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way..	0	1	2	3
Column totals	___	+ ___	+ ____	+ ___

= ***Total Score*** _____

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