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 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ Male ☐ Female **Date:** _____

Relationship with the child: _____

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

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

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?	○	○

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**
☐	☐	☐	☐

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* _____