Health care that revolves around you

Behavioral Health Appointment Policy

We want to provide you with quality health care. To do this, it is very important that you keep your scheduled appointments and arrive on time. We have reserved that time especially for you and want to make sure that we work together to meet your health care needs.

Your appointments are important to your health.

- Keep all of your scheduled appointments.
- Cancel your appointment if you know you cannot keep it, as soon as possible, preferably by the day before the appointment so that we may offer it to someone else. (Call 877-800-5722)
- Arrive on time for program registration and medical appointments.

What happens if you don't come to an appointment and don't cancel it ("No show")?

- If you "no show" for an appointment or cancel your appointment with less than 24 hours notice, your provider will contact you to find out why you did not show up, to review this appointment policy with you, and to see whether you can reschedule with them. Please call us and let us know if you are having difficulty coming to your appointments.

- If you "no show" for a 2nd appointment without speaking to your provider, your provider will try to contact you again to find out why, and then will decide whether you should still be seen by them. If the provider decides that they should not see you as their patient anymore, you will receive a letter from your provider stating so. If you wish, you may appeal your provider's decision to stop seeing you. The appeal process will be outlined in the letter you receive. If you provider decides not to see you anymore, you may still be seen by other providers at Lone Star Circle of Care.

- If your provider decides not to see you anymore and you decide not to appeal, but still want to see your original provider, you may, after 6 months, reapply for services with your provider. You must, at that time, agree to follow all clinic policies (outlined here) in order to be seen by the provider.

What happens if you are late?

- If you are more than 10 minutes late for your scheduled arrival time, you may experience a longer-than-usual wait time, as we may have to work you into the schedule later.

- If we are unable to work you into the schedule later in the day, you may be asked to reschedule your appointment.

Patient Name: ______________________________

Patient Signature:__________________________ **Date:**______________________

Revised 3/2012

Name:__________________________ Date of birth:__________________ Date:_______________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING ___0___ + _______ + _______ + _______

=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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Date: ____________

CHILD HEALTH HISTORY FORM

Child's Name: ______________________________ **DOB:** ____________________

Person Answering Questions

Name: ______________________________ **Relationship to Child:** ____________________

Why are you seeking help for your child?______________________________

Who referred you to us? ______________________________

What kind of behavioral health services are you seeking for your child? ___ **Therapy/Counseling Only**

___ **Psychiatric Evaluation and Possible Psychotropic Medication Management (Med Mgmt)**

____ **Combination Therapy and Med Mgmt Other:** ______________________________

LSCC strives to offer quality care for your child through a behaviorally-enhanced, integrated care model (behavioral health with pediatric services). Are you interested in learning more about this? ___**Yes** ___**No.**

Who is your current pediatrician/nurse practitioner/family doctor? ____________________

Do you have a current therapist? Please provide their name and location: ____________________

Language spoken at home: ____ **English** ____ **Spanish** ____ **Other:** ____________________

Mother's Name: ____________________**Age:** ___ **Father's Name:** ____________________**Age:**____

Occupation/Employer: ____________________**Occupation/Employer:** ____________________

____________________ ____________________

Highest Education Completed: ____________________ **Highest Education Completed:** ____________________

Other Primary Caregivers: ______________________________

If parents separated/divorced, custody arrangement: ______________________________

List other children living in the home and any siblings living outside of the home:

Name	Age	Sex	Relationship to Child	Living at Home?

Number of family moves since your child was born: ______ Any foster care placement? _____Yes _____ No

Other family or residential placements? ____ Yes ____ No Describe: ______________________________

DEVELOPMENTAL/SOCIAL/MEDICAL HISTORY - "PARENT'S REPORT REGARDING CHILD"

Instructions: Please read each question, mark an 'X" in the appropriate box and add comments where needed.

Mother's Pregnancy with Child: Delivery: ___ Vaginal ___ C-Section Labor induced: __ Y __ N

Forceps used: _Y _N Were there complications? __Y __N

If Yes, ___Diabetes ___Premature Labor ___Toxemia ___ Pre-eclampsia ___ other: ______________

Full Term Pregnancy: __Y __N If "No", at how many weeks was your child born? ____________
How long did your child remain in the hospital after giving birth? ____________________________
Any other comments? (i.e., jaundice, twin birth, breathing problems at birth). Please explain:

____

How much did your child weigh? ____ lbs ____ oz
Was tobacco, alcohol, prescription medications (in addition to Prenatal Vitamins) or street drugs used during pregnancy? ___Y ___N If "yes", please explain:

____

DEVELOPMENTAL:	**Early**	**Normal**	**Late**
~~Sat without support~~	~~___<6 months~~	~~___7 – 8 months~~	~~___ 9 months or older~~
Crawled by scooting	___ 8 months	___ 9 months	___ 10 months or older
Stood Alone	___ 10 months	___ 11 months	___ 12 months or older
Said 2 words other than "mama/ dada"	___ 10 months	___ 11 months	___ 12 months or older
Walked alone	___ 11 months	___ 12 months	___ 13 months or older
Walked alone well	___ 11 months	___ 15 months	___ 16 months or older
Said 3-6 words	___ 14 months	___ 15 months	___ 16 months or older
Put 2 words together	___ before 2 years	___ 2 years	___ older than 2 years
Potty trained (Out of diapers)	___ 2 ½ - 3 years	___ 3 – 3 ½ years	___ older than 3 ½ years

Social: Does your child talk easily with others? ___Y ___N Does your child have friends? ___Y ___N
Does your child play well with other children? ___Y ___N Is your child sexually active? ___Y ___N
(comments):____

Support System: Does your child have supportive relationships? ___Parents ___Close Friends ___Boyfriend/Girlfriend ___Guardians ___Siblings ___ Aunts/Uncles ___ Close friends ___ Church Family ___ Other: _____

Eating Habits: Is your child a picky eater? ___ Y ___ N Any unusual eating habits? (i.e., dirt/paper)?
___ Y ___ N: Describe: ______________________________________Number of meals/day: ____

Sleeping: How many hours does your child sleep? ____How long does it take your child to fall asleep?____
Does your child have nightmares? ___Y ___N If your child wets the bed, how often does this occur? ____
Sleep walking? ___Y ___N Night terrors? ____Y ____N Other:_____________________________

Pain: Is your child experiencing any pain now? ____ Y ___ N (explain):______________________
Has your child had any pain during the past 2 months? ___ Y ___ N Score: 0-10 (10 being worst): _____
(explain if yes):____

MEDICAL REVIEW* OF *SYSTEMS - "PARENT'S REPORT"

Please circle problems your child/adolescent is experiencing.

EYES. EARS. NOSE AND MOUTH ___ no problems
Glaucoma
Teeth Problems
Visual Loss
Double Vision
Red/Pink Eye

GASTROINTESTINAL ___ no problems
Stomach Aches
Nausea
Vomiting
Acid Reflux Disease

Hearing Loss
Discharge from Ears
Nasal Obstruction
Discharge from Nose/Nose Bleeds
Head or Throat Pain
Other: ______________________________

Constipation
Hemorrhoids
Blood in Stools
Black Stools
Loss of Bowel Control
Other: ______________________________

ENDOCRINE/SKIN ___ no problems

Increased Sweating
Can't tolerate cold/heat
Extreme Fatigue
Change in Blood Cell Count
Enlarged Lymph Nodes
Increased Thirst/Dry Mouth
Increased Appetite
Increased Urination
Bruising or Scaling of Skin
Rash and/or itching skin
Other: __________________________________

GENITOURINARY ___ no problems

Kidney Problems/Pain/Stones
Jaundice (yellow skin)
Bladder Infection
Painful Urination
Blood in Urine
Frequent Nighttime Urination
Nighttime Incontinence (bed wetting)
Daytime Incontinence
Sexually Transmitted Diseases (STD's)
Vaginal/Penile Discharge
Last menstrual period (if applicable):_______
Other: _______________________________

CARDIOVASCULAR ___ no problems
Structural Defects/Abnormalities: ____________
Heart skips a beat/Arrhythmia
History of Heart Murmurs
Increased Heart Rate
Slowed Heart Rate
Chest Pain
Swelling of Feet
Episode of Fear/Panic
Fear of Dying
Other: ___________________________

NEUROLOGICAL ___ no problems
Dizziness
Headaches
Migraines
Blacking Out/Passing Out Seizures
Loss of Sensations Tremors or Tics
Speech Problems
Sleep Problems
Walking Problems
Other: ________________

RESPIRATORY ___ no problems
Shortness of Breath/ Asthma
Wheezing
Pneumonia
Chronic Cough
Coughing Up Blood
Fever
Night Sweats

MUSCULOSKELETAL ___ no problems
Fractured Bones
Painful Joints
Stiff or Swollen Joints
Night Cramps
Night Sweats
Muscle Weakness
Other: _________________________

If your child/adolescent has experienced any of the above in the past, please comment here:

____

Any self-injurious behaviors? (i.e., self-biting, hitting, cutting, burning). Describe: __________________________

When was your child's last physical exam?__________________last dental exam? _______________________

Has your child ever had an elevated "lead level"? ____ Y ____ N

Has your child ever had the following tests?:

Hearing tests/Vision tests ___ Y ___ N EEG (Brain wave tests)? ___ Y ___ N

CAT scan/MRI (Brain Scan) ___ Y ___ N EKG (heart test)? ___ Y ___ N

Neurological Evaluation ___ Y ___ N : ______________________________

Does your child have a history of head trauma? ___ N ___ Y *If yes, please explain:* ______________

At what age? _____ Was there a loss of consciousness? ___ Y ___ N

Medical hospitalizations? ___ Y ___ N *If yes, list year and the reasons:* ______________

____

Surgeries/operations? ___ Y ___ N *If yes, list year and the reasons:* ______________

Immunizations Received: _____ Up-to-date ____ details unknown

Has your child ever had Chicken Pox? ___ Y ___ N If yes, when and at what age? ______________

Family Medical/Psychiatric History:

Has the child/adolescent's immediate and extended family members ever had (please circle and indicate which family member (i.e., maternal aunt): Sudden death before age 35 due to heart problems ______________

Heart Problems ______________ Migraines ______________

Seizures ______________ Thyroid ______________

Multiple Sclerosis ______________ High Blood Pressure ______________

Diabetes ______________ Lung Problems ______________

Stomach Problems ______________ Arthritis ______________

Cancer ______________ Kidney Problems ______________

Reading Problems ______________ Other Learning Disabilities ______________

Speech/Language Problems: ______________ Special Education ______________

Autism ______________ Mental Retardation ______________

Tuberculosis: ______________ Other ______________

____

Psychological Problems/Mental Illness (Details will be asked during the appointment)

____

____

Alcohol Abuse ______________ Drug Abuse ______________

Please list any other medical concerns here: ______________

____

Any Allergies?: ____No. ___ Yes: please list (i.e., specific medication(s), foods, environmental (i.e., cedar, cat dander):______________

PAST PSYCHIATRIC HOSPITALIZATIONS, RESIDENTIAL TREATMENT CENTER PLACEMENTS:

____

____

____

CURRENT PRESCRIBED MEDICATIONS:

CURRENT NON-PRESCRIPTION MEDICATION/HERBAL SUPPLEMENTS – VITAMINS (Used Regularly)

MEDICATION RECORD – PARENT'S REPORT' Please CIRCLE the medications taken in the PAST and indicate the maximum dose taken and why the medication was stopped.

NONE	Maximum Dose and Reason Stopped		Maximum Dose and Reason Stopped
ANTI-DEPRESSANTS		**STIMULANTS**	
Celexa (Citalopram)		Adderall (Dextroamphetamine Mixed Salts)	
Desyrel (Trazodone)		Adderall XR	
Effexor XR (Venlafaxine)		Concerta (MethylphenidateER)	
Luvox (Fluvoxamine)		Dexedrine (Dextroamphetamine)	
Paxil (Paroxetine)		Dexedrine Spansule	
Prozac (Fluoxetine)		Metadate CD/Metadate ER	
Remeron (Mirtazapine)		Ritalin (Methylphenidate)	
Serzone (Nefazadone)		Ritalin SR	
Tofranil (Imipramine)		Ritalin LA	
Wellbutrin/SR (Buproprion)		Focalin/FocalinXR (Dexmethylphenidate)	
Wellbutrin XL		DaytranaPatch	
Cymbalta (Duloxetine)		Vyvanse (Lisdexamfetamine)	
Lexapro (Escitalopram)		**ANTI-PSYCHOTICS**	
Zoloft (Sertaline)		Orap (Pimozide)	
Cymbalta (Duloxetine)		Risperdal (Risperidone)	
MAOI/Emsam/Nardil		Seroquel (Quetiapine)	
MOOD STABILIZERS		Thorazine (Chlorpromazine)	
Depakote(Divalproex Sodium, Valproic Acid)		Zyprexa (Olanzapine)	
Depakote ER		Mellaril (Thioridazine)	
Lithium		Abilify (Aripripazole)	
Lithobid(Lithium Carbonate)		Clozaril (Clozapine)	
Eskalith CR (Lithium CR)		Geodon (Ziprasidone)	

Neurontin (Gabapentin)		Haldol (Haloperidol)	
Lamictal (Lamotrigine)		Symbyax	
Tegretol (Carbamazepine)		**BENZODIAZEPINES**	
Topamax (Topirarmate)		Ativan (Lorazepam)	
Trileptal (Oxcarbamazepine)		Klonopin (Clonazepam)	
OTHER MEDS		Xanax (Alprazolam)	
Intuniv (Guanfacine)/Tenex		Ambien (Zoldipem)	
Strattera (Atomoxetine)		~~Sonata (Zaleplon)~~ Lunesta Rozerem	
Benadryl/Diphenhydramine		Catapres (Clonidine)	
BuSpar (Buspirone)		Cogentin (Benztropine)	
Clonidine		Vistaril (Hydroxyzine)	

Education: Current grade: ________ School: ______________________________ District: ______________

Ever repeated a grade? Which one? ______________ Current Grades: ______________________________

_____ Regular Classes _____ Resource _____ Special Educ _____ GT/TAG _____ Alternative

Legal: _____History of Legal charges (circle: current pending past) For what? _________________

_____ History of Detention/Probation? Where and when: ____

Alcohol/Substance Abuse: Do you suspect alcohol or substance abuse for your child? If yes, please explain:

____

Abuse: Do you know/or suspect physical or sexual abuse for your child? If yes, please explain briefly:

____

Do you know/or suspect your child has sexually abused another person? If yes, please explain briefly:

____

Has CPS ever been or is currently involved? If yes, please explain briefly:

____

Has your child witnessed domestic violence? If yes, please explain briefly:

____

SAFETY ASSESSMENT:

Are there guns in your home? __ Yes __ No. If yes, is there safe firearm storage? (i.e., locking guns, locking and separating ammunition, keeping guns unloaded) __ Yes __ No **For safety, which of the following would you be willing to do (check all that apply)?** __ Remove guns from home __ Leave guns in home, safely stored __ Lock down sharps (i.e., knives, razors, axes, saws, other tools, etc.) __ Lock down all flammables (i.e., gasoline, lighter fluid, etc.) and lighters __ Lock down chains and ropes __ Lock down all over-the-counter and prescription medications

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ____________ Child's Name: ______________________________________ Date of Birth: ______________

Parent's Name: ______________________________________ Parent's Phone Number: __________________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. I physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil

Consumer & Specialty Pharmaceuticals

Today's Date: ____________ Child's Name: ______________________________ Date of Birth: ______________

Parent's Name: ______________________________ Parent's Phone Number: ______________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ______________

Total number of questions scored 2 or 3 in questions 10–18: ______________

Total Symptom Score for questions 1–18: ______________

Total number of questions scored 2 or 3 in questions 19–26: ______________

Total number of questions scored 2 or 3 in questions 27–40: ______________

Total number of questions scored 2 or 3 in questions 41–47: ______________

Total number of questions scored 4 or 5 in questions 48–55: ______________

Average Performance Score: ______________

Brief Multidimensional Students' Life Satisfaction Scale (Huebner, 1997)

These six questions ask about your satisfaction with different areas of your life.
Circle the best answer for each.

	Terrible	Unhappy	Mostly Dissatisfied	Mixed (about equally and dissatisfied)	Mostly Satisfied	Pleased	Delighted
1. I would describe my satisfaction with my family life as:	1	2	3	4	5	6	7
2. I would describe my satisfaction with my friendships as:	1	2	3	4	5	6	7
3. I would describe my satisfaction with my school experience as:	1	2	3	4	5	6	7
4. I would describe my satisfaction with myself as:	1	2	3	4	5	6	7
5. I would describe my satisfaction with where I live as:	1	2	3	4	5	6	7
6. I would describe my satisfaction with my overall life as:	1	2	3	4	5	6	7
Total	____	_____	_____	_____	_____	_____	_____

Total _______

÷ 6 = _______
Score

In order to help us better understand you/your child and meet your needs, please answer the questions below. Some of these questions might not apply to you/your child. In that case, please answer "No." ***Thank you***

What is your pain level on a scale of 1 (none) – 10 (worst)? ________________ *Reference: Wong-Baker FACES® Pain Rating Scale*.

- o Yes o No Have you had a full medical exam in the last year?
  When? ______________________
  By whom? ______________________
  Where? ______________________

- o Yes o No Do you have a Psychiatric Advanced Directive (PAD)? *A Psychiatric Advanced Directive is a legal document that allows another person to act on your behalf if you become acutely ill and unable to make decisions about treatment.*
- o Yes o No Do you have any of the concerns listed below:
  - Unintended weight change of 10 or more pounds in the last 3-6 months?
  - An illness or problem that made you change the kind and/or amount of food you eat?
  - Tooth or mouth problems that make it hard for you to eat?
  - A big change in desire to eat, or food intake, over the last 2 weeks?
- o Yes o No Are you able to take care of yourself like you used to, or do things like you used to?
- o Yes o No Are you having trouble with your finances? Are you able to pay for the things you need?
- o Yes o No Do you have constant, repeated difficulties with gambling that cause you to suffer emotionally? Personally? Professionally?
- o Yes o No Are you having trouble reaching your goals in school? Or because of your educational level?
- o Yes o No Are you having trouble reaching your goals at work? Or because of your work status?
- o Yes o No Are you having trouble reaching your goals because of legal problems?
- o Yes o No Are there things about your cultural identity that impact your reasons for seeking help?
  Are there things about your cultural identity that are causing difficulties for you?
- o Yes o No Are you sexually active?
- o Yes o No Are you being forced to have sex?
- o Yes o No Is anyone sexually threatening you, or hurting you? Touching you in a way that makes you uncomfortable?
- o Yes o No Is anyone physically threatening, or hurting you? Bullying you?
- o Yes o No Is anyone verbally or emotionally threatening, or hurting you? Making you feel bad about yourself?
- o Yes o No Is anyone keeping you from:
  - Talking to who you want to?
  - Going where you want to go?
  - Seeing who you want to see?
  - Having food, water, clothing or a place to stay?
  - Going to the doctor or having medicine?
  - Using your money?

Other comments:____

For Office Use only:

Referral to Primary Care	○ **Not indicated, per screen**	○ **Submitted via NextGen**	○ **Complete/ROI for outside PCP sent**	○ **Deferred due to:** ____________	○ **Patient Declined**
Referral to Nutrition	○ **Not indicated, per screen**	○ **Submitted via NextGen**	○ **Resources Letter Generated**	○ **Deferred due to:** ____________	○ **Patient Declined**
Other referral(s):	____________	○ **Submitted via NextGen**	○ **Resources Letter Generated**	○ **Deferred due to:** ____________	○ **Patient Declined**
	____________	○ **Submitted via NextGen**	○ **Resources Letter Generated**	○ **Deferred due to:** ____________	○ **Patient Declined**
	____________	○ **Submitted via NextGen**	○ **Resources Letter Generated**	○ **Deferred due to:** ____________	○ **Patient Declined**

____

Provider Name and Credentials (Print) **Provider Signature** **Date**

Name/Nombre_________________________________ Date/Fecha___________________

Date of Birth/Fecha de Nacimiento_______________

CAGE-AID + 1 Questionnaire

Yes	No	Have you ever felt you ought to cut down in your drinking or drug use?
Yes	No	Have people made you mad by criticizing your drinking or drug use?
Yes	No	Have you felt bad or guilty about your drinking or drug use?
Yes	No	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?
Yes	No	In the past year, have you used an illegal drug or used a prescription medication for non-medical reasons (to get high)? How Many Times?_________
		How many times In the past year have you had 5 (for men) or 4 (for women and all adults older than 65) or more drinks in a day? ___________________

Español

Sí	No	¿Ha sentido alguna vez usted debe reducir su consumo de alcohol o el uso de drogas?
Sí	No	¿Ha estado enojado alguna vez porque la gente critica su uso de alcohol o consumo de drogas?
Sí	No	¿Sentido mal o culpable sobre su uso de alcohol o drogas?
Sí	No	¿Alguna vez un trago o usado drogas primero por la mañana para calmar su nervios o deshacerse de una resaca?
Sí	No	¿ Durante el año pasado, ha usado una droga ilegal o utiliza un medicamento de prescripción por razones no médicas (para drogarse)? ¿Cuántas veces?_________
		En el año pasado ¿Cuántas veces ha tomado más de 5 (para hombres) o 4 (para mujeres y para todos los adultos mayores de 65 años de edad) bebidas alcohólicas en un día? ____________________

Last revised 3.16.2016

Self-Assessment Questionnaire

Name:________________________Date of Birth:_____________________ Date:_____________________

For each statement, please mark the answer that best fits your situation. If you are unsure about how to answer any of these statements, please speak to your provider for clarification. Some of these questions may not apply to you or your child, in that case please answer "No." If you are a parent answering for your child, please answer questions from your child's point of view.

Historical Factors		
No	Yes	
		Have you ever had a family member or close friend try to kill themselves?
		Have you ever tried to kill yourself or hurt yourself on purpose?
		Have you ever had thoughts of killing or hurting yourself on purpose?
		Have you ever acted without thinking or without self-control in a way that put yourself or others in danger?

Current Factors		
No	Yes	
		In the past 6 months have you tried to kill yourself or hurt yourself on purpose?
		In the past 6 months have you acted without thinking or without self-control in a way that put yourself or others in danger?
		In the past 6 months have you been violent or aggressive towards people or property?
		In the past 6 months have you had thoughts of killing yourself or hurting yourself on purpose?
		Do you have any plans to kill or hurt yourself or others?
		Are you having a problem making goals or plans for the future?
		Do you intend to harm or kill yourself?
		Do you have difficulty following your doctor or therapist treatment instructions?
		Have you written a suicide note or have you begun giving your important belongings away to others?

Provider Name & Credentials (print):__________________________
Provider Name & Credentials (signature):_________________________ Date:________________________

Last revised 3.16.2016

Self-Assessment Questionnaire

No	Yes	
		Have you heard things that other people don't hear? Do they tell what to do?
		Are you losing hope or feel that you are helpless?
		Do you feel like your life has no value or purpose?
		Are you having trouble with sleeping?
		Are you keeping yourself from being with people or doing things with others?
		Do you feel guilty, bad about yourself, or ashamed of yourself?
		Are you feeling more angry or alone?
		Do you feel like your emotions are always "up and down" or out of control?
		Do you feel like you are not safe or that something bad will happen to you?
		Do you have chronic, repeated, or constant pain?

Situational Factors		
No	Yes	
		Do you feel sick when you don't use alcohol or drugs for a short period of time?
		Do you have a long-lasting, serious illness?
		Have you had a recent loss? (example: death of a loved one, loss of a job, divorce or separation)
		Have you had any other recent bad news?
		Do you often argue with friends or co-workers?

Protective Factors		
No	Yes	
		Do you have support from family?
		Do you have support from your spouse/significant other?
		Are you in charge of caring for children or other family?
		Do your friends provide you support when needed?
		Do you have strong religious or spiritual beliefs that keep you safe from hurting yourself?

No	Yes	
		Did you graduate high school or earned your GED?
		Do you have a good way to handle difficult situations?

Provider Name & Credentials (print):___________________________

Provider Name & Credentials (signature):_________________________ Date:________________________