

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:	

Name:	Date of birth:	Date:
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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u> , how by any of the following pro (Use """ to indicate your an		Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure i	in doing things	0	1	2	3
2. Feeling down, depressed,	or hopeless	0	1	2	3
3. Trouble falling or staying a	asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having littl	e energy	0	1	2	3
5. Poor appetite or overeating	ng	0	1	2	3
6. Feeling bad about yoursel have let yourself or your fa	If — or that you are a failure or amily down	0	1	2	3
7. Trouble concentrating on newspaper or watching te		0	1	2	3
noticed? Or the opposite	owly that other people could have — being so fidgety or restless ng around a lot more than usual	0	1	2	3
Thoughts that you would be yourself in some way	oe better off dead or of hurting	0	1	2	3
	For order our				
	FOR OFFICE COD	JING <u>U</u> +		Total Score:	
	blems, how <u>difficult</u> have these t home, or get along with other		ade it for	you to do y	our/
Not difficult at all □	Somewhat difficult □	Very difficult □		Extreme difficul	

Name:	Date:
	Date:

Quality of Life Enjoyment and Satisfaction Questionnaire - Short Form (Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your......

	Very Poor	Poor	Fair	Good	Very Good
physical health?	1	2	3	4	5
mood?	1	2	3	4	5
work?	1	2	3	4	5
household activities?	1	2	3	4	5
social relationships?	1	2	3	4	5
family relationships?	1	2	3	4	5
leisure time activities?	1	2	3	4	5
ability to function in daily life?	1	2	3	4	5
sexual drive, interest and/or performance?*	1	2	3	4	5
economic status?	1	2	3	4	5
living/housing situation?*	1	2	3	4	5
ability to get around physically without feeling dizzy or unsteady or falling?*	1	2	3	4	5
your vision in terms of ability to do work or hobbies?*	1	2	3	4	5
overall sense of well being?	1	2	3	4	5
TOTALS	+	+	+		+
medication? (If not taking any, check here and leave item	4		2	4	E
blank.)How would you rate your overall life satisfaction and contentment during the past week?		2	3	4	5

^{*}If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.



Mood Questionnaire

Nai	me:	L)UB:	Date:		
Г						
	Pleas	e Check <u>ONE BOX ON</u>	<u>LY</u> for each of the questic	ons below.		
1.	Has there ever b	een a period of time v	when you were not your	usual self	YES	NO
	you felt so good normal self, or yo	u were so hyper you go	people thought you were not into trouble? at people or started fights			
	you felt much m you got much le		usual? I found you didn't really mi spoke much faster than us			
	thoughts raced t	through your head and ily distracted by things	or you couldn't slow your around you that you had t	mind down?		
	you had much m	nore energy than usual more active and/or dic	? I many more things than u g than usual-for example, y			
	telephoned friend you were much	s in the middle of the n more interested in sex	night?			
	thought were exce	essive, foolish or risky? got you or your family	,	gnt nave		
2.		ES to more than one o	of the above, have you expod of time?	perienced		
3.	_	-	ese situations cause you (problems; and/or getting	_		ents
	No problem □	Minor problem □	Moderate problem □	Serious pro	oblem	

This questionnaire will be discussed with your provider.



LSCC -	Behavioral	Health	Intake/	Initial	Evaluation	Screening	Questions

Last updated: 03/08/16 Patient Name: ______ Patient DOB: ______ Date: _____

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

٧	√hat is y	your	pain le	evel on a scale of 0 (none) – 10 (worst)? L	ocation/Nature of Pain:						
0	Yes	0	No	Have you had a full medical exam in the last year?							
0		0		When? By whom?	Where						
0	Yes	0	No	Do you have a Psychiatric Advanced Directive (PAD)? A Psy your behalf if you become acutely ill and unable to make decision	chiatric Advanced Directive is a legal document that allows another person to act on sabout treatment.						
0	Yes	0	No	Do you have any of the concerns listed below:							
				 Unintended weight change of 10 or more pounds in the 	e last 3-6 months?						
				 An illness or problem that made you change the kind a 	nd/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 la 	ast 2 weeks?						
0	Yes	0	No	Are you able to take care of yourself like you used to, or do	things like you used to?						
0	Yes	0	No	you having trouble with your finances? Are you able to pay for the things you need?							
0	Yes	0	No	Do you have constant, repeated difficulties with gambling t	o you have constant, repeated difficulties with gambling that cause you to suffer emotionally? Personally? Professionally?						
0	Yes	0	No	Are you having trouble reaching your goals in school? Or be	re you having trouble reaching your goals in school? Or because of your educational level?						
0	Yes	0	No	Are you having trouble reaching your goals at work? Or bed	cause of your work status?						
0	Yes	0	No	Are you having trouble reaching your goals because of lega	l problems?						
0	Yes	0	No	Are there things about your cultural identity that impact yo	ur reasons for seeking help?						
				Are there things about your cultural identity that are causing	ng difficulties for you?						
0	Yes	0	No	Are you sexually active?							
0	Yes	0	No	Are you being forced to have sex?							
0	Yes	0	No	Is anyone sexually threatening you, or hurting you? Touchi							
0	Yes	0	No	Is anyone physically threatening, or hurting you? Bullying y							
0	Yes	0	No	Is anyone verbally or emotionally threatening, or hurting ye	ou? Making you feel bad about yourself?						
0	Yes	0	No	Is anyone keeping you from: • Talking to who you wa	nt to?						
				 Going where you want 	to go?						
				 Seeing who you want t 	o see?						
				 Having food, water, clo 	othing or a place to stay?						

• Going to the doctor or having medicine?

• Using your money?

Patient Name:	Patient DOB:	Date:



For Office Use only: Referral to Primary Care	0	Not indicated, per screen	0	Submitted via NextGen	0	Complete/ROI for outside PCP sent	0	Deferred due to:	0	Patient Declined
Referral to Nutrition	0	Not indicated, per screen	0	Submitted via NextGen	0	Resources Letter Generated	0	Deferred due to:	0	Patient Declined
Other referral(s):			0	Submitted via NextGen	0	Resources Letter Generated	0	Deferred due to:	0	Patient Declined
			0	Submitted via NextGen	0	Resources Letter Generated	0	Deferred due to:	0	Patient Declined
			0	Submitted via NextGen	0	Resources Letter Generated	0	Deferred due to:	0	Patient Declined
Provider Name an	d Cr	edentials (Print)			P	rovider Signature			Date	

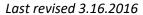
Name/Nombre	Date/Fecha				
Date of Birth/Fecha de Nacimiento					

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

No	¿Ha sentido alguna vez usted debe reducir su consumo de alcohol o el uso de drogas?
No	¿Ha estado enojado alguna vez porque la gente critica su uso de alcohol o consumo de drogas?
No	¿Sentido mal o culpable sobre su uso de alcohol o drogas?
No	¿Alguna vez un trago o usado drogas primero por la mañana para calmar su nervios o deshacerse de una resaca?
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?
	No No No





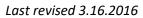
Self-Assessment Questionnaire

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.

Histo	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?	
	•		

Curre	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?	





Self-Assessment Questionnaire

Name:	Date of Birth:	Date:

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?

Situatio	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?	

Protect	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?