Lone ★ Star Circle of Care *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

ADULT HEALTH HISTORY FORM

Name: _____ DOB: _____ Date:_____

Why are you seeking help?_____

_____

What kind of behavioral health services are you seeking?

____ Therapy/Counseling Only

_____Psychiatric Evaluation and Possible Psychotropic Medication Management (Med Mgmt)

_____ Combination Therapy and Med Mgmt Other: _____

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

Do you have a current psychiatrist? Please provide their name and location:_____

Do you have a current primary care doctor? Please provide their name and location:_____

_____

Other specialists/doctors treating you (i.e., speech therapist, neurologist):

_____

Language spoken at home: ____ English ____ Spanish ____ Other: _____

Occupation/Employer: _____

Highest Education Completed: _____

Marital Status: Single Married Divorced Remarried Widowed Other

Household family members:

Name	Age	Sex	Relationship to you

DEVELOPMENTAL/SOCIAL/MEDICAL HISTORY

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

Current Mental Health Diagnoses: _____

Past Mental Health Diagnoses:_____

Do you have an advance psychiatric directive?_____

Social: Do you talk easily with others? ___Y ___N Do you have friends? ___Y ___N

Support System: Do you have supportive relationships? ___Parents ___Children ___Spouse __Siblings ___ Aunts/Uncles ___ Close friends ___ Church Family ___ Other: _____

Eating Habits: Do you have issues with your eating or your appetite? __Y __N

Please explain:_____

_____

Sleeping: How many hours do you sleep? ____How long does it take you to fall asleep?____ Do you have nightmares? ___Y ___N

Sleep walking? ___Y ___ N Night terrors? ____Y ____ N Other:_____

Pain: Are you in any pain now? ____ Y ___ N Paine Score: 0-10 (10 being worst): _____ (explain if yes):_____

When was your last physical exam? _____ last dental exam? _____

Neurological Evaluation ___ Y ___ N : _____

Do you 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:* _____

_____

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

_____

_____

Alcohol Abuse _____ Drug Abuse _____

Please list any other medical concerns here: _____

_____

Any Allergies? ____N ___ Y please list specific medication(s), foods, environmental allergies:

_____

PAST PSYCHIATRIC HOSPITALIZATIONS, RESIDENTIAL TREATMENT CENTER PLACEMENTS:

CURRENT PRESCRIBED MEDICATIONS:

_____

CURRENT NON-PRESCRIPTION MEDICATION/HERBAL SUPPLEMENTS/VITAMINS:

_____

Legal: _____History of Legal charges (circle: current pending past) For what? _____
_____ History of Probation/Jail/Prison? Where and when:_____

_____

Abuse: Any history of physical or sexual abuse.? If yes, please explain briefly:

Has CPS ever been or is currently involved? 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

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.

Name:_____ Date of Birth:_____ Date:_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Mood Questionnaire

Name:_____ Date of Birth:_____ Date:_____

Please Check ONE BOX ONLY for each of the questions below.			
1.	**Has there ever been a period of time when you were not your usual self and…**	**YES**	**NO**
	…you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper 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 and/or spoke much faster than usual?		
	…thoughts raced through your head and/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 and/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 you experienced several of these during the same period of time?**		
3.	**How much of a problem did any of these situations cause you (like being unable to work; having family, money, or legal problems; and/or getting into serious arguments or fights)?** No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem ☐		

This questionnaire will be discussed with your provider.

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool. *Derived from Hirschfeld RM. Am J Psychiatry. 2000:157(11):1873-5

Audit-C Questionnaire

Patient Name:_____ Date of Birth:_____ Date of Visit:_____

1. How often do you have a drink containing alcohol?
    - Never
    - Monthly or Less
    - 2-4 times a month.
    - 2-3 times a week
    - 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
    - 1 or 2
    - 3 or 4
    - 5 or 6
    - 7 to 9
    - 10 or more

3. How often do you have six or more drinks on one occasion?
    - Never
    - Less then monthly
    - Monthly
    - Weekly
    - Daily or almost daily

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Name:_____ Date of birth:_____ 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 blank.)	1	2	3	4	5
.....How would you rate your overall life satisfaction and contentment during the past week?	1	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.**

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

The scoring of the Q-LES-Q-SF involves summing only the first 14 items to yield a raw total score. The last two items are not included in the total score but are stand-alone items. The raw total score ranges from 14 to 70. The raw total score is transformed into a percentage maximum possible score using the following formula:

$$\frac{\text{(raw total score } - \text{minimum score)}}{\text{(maximum possible raw score } - \text{minimum score)}}$$

The minimum raw score on the Q-LES-Q-SF is 14, and the maximum score is 70. Thus the formula for % maximum can also be written as (raw score −14)/56. The table below converts total raw scores into % maximum scores.

Raw Score	% Maximum	Raw Score	% Maximum	Raw Score	% Maximum	Raw Score	% Maximum
14	0	28	25	42	50	56	75
15	2	29	27	43	52	57	77
16	4	30	29	44	54	58	79
17	5	31	30	45	55	59	80
18	7	32	32	46	57	60	82
19	9	33	34	47	59	61	84
20	11	34	36	48	61	62	86
21	13	35	38	49	63	63	88
22	14	36	39	50	64	64	89
23	16	37	41	51	66	65	91
24	18	38	43	52	68	66	93
25	20	39	45	53	70	67	95
26	21	40	46	54	71	68	96
27	23	41	48	55	73	69	98
						70	100

Citation: Endicott J, Nee J, Harrison W, Blumenthal R. Quality of Life Enjoyment and Satisfaction Questionnaire: A New Measure. Psychopharmacology Bulletin 1993;29:321-326.

LSCC - Behavioral Health Intake/Initial Evaluation Screening Questions Last updated:3/8/16

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***

What is your pain level on a scale of 0 (none) – 10 (worst)?_____Location/Nature of Pain:_____

- ○ Yes ○ No Have you had a full medical exam in the last year?
- ○ ○ When?_____By whom?_____Where _____
- ○ Yes ○ 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.*
- ○ Yes ○ No Do you have any of the concerns listed below (please check all that apply)
  - ○ 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?
  - ○ Do you worry that you have lost control over how much you eat? Do you make yourself vomit when you feel uncomfortably full? Do you eat in secret?
- ○ Yes ○ No Are you able to take care of yourself like you used to, or do things like you used to?
- ○ Yes ○ No Are you having trouble with your finances? Are you unable to pay for the things you need?
- ○ Yes ○ No Do you have constant, repeated difficulties with gambling that cause you to suffer emotionally? Personally? Professionally?
- ○ Yes ○ No Are you having trouble reaching your goals in school? Or because of your educational level?
- ○ Yes ○ No Are you having trouble reaching your goals at work? Or because of your work status?
- ○ Yes ○ No Are you having trouble reaching your goals because of legal problems?
- ○ Yes ○ 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?
- ○ Yes ○ No Are you sexually active?
- ○ Yes ○ No Are you being forced to have sex?
- ○ Yes ○ No Is anyone sexually threatening you, or hurting you? Touching you in a way that makes you uncomfortable?
- ○ Yes ○ No Is anyone physically threatening, or hurting you? Bullying you?
- ○ Yes ○ No Is anyone verbally or emotionally threatening, or hurting you? Making you feel bad about yourself?
- ○ Yes ○ 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:_____

Last updated: 03/08/16

Patient Name: _____ Patient DOB: _____Date: _____

For Office Use only:

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

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

Lone ★ Star Circle of Care

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?

Lone ★ Star Circle of Care

Last revised 3.16.2016

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?

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?