BLUE VALLEY BEHAVIORAL HEALTH- Registration

Admission Date: _____ Location: _____

CLIENT DEMOGRAPHIC INFORMATION

Last Name: _____ First: _____ MI: Suffix: _____

Previous Last/Maiden Name: _____ Nickname: _____

Mailing Address: _____ City: _____ State: Zip: _____

County of Residence: _____ County of Admission: _____

Phone Contact:
Home #:
Cell #:

Preferred Contact Manner:
○ Home Leave Message Y / N
○ Cell Leave Message Y / N

Date of Birth: _____ **Age:** _____ **Gender:** _____ **Social Security Number:** _____

Are you referred by a medical provider/care setting? Y / N

Race: ○ Alaska Native ○ American Indian ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ White

Ethnicity: ○ Cuban ○ Hispanic (specific origin unknown) ○ Mexican ○ Not of Hispanic Origin ○ Other Specific Hispanic ○ Puerto Rican ○ Unknown

Preferred Language: **US Citizen** Y / N **Immigration Number:**

VOTER REGISTRATION: Are you currently registered to vote? Y / N Would you like to receive an application today? Y/ N

Is youth/family involved with Juvenile Court? Y / N Is youth receiving services voluntarily w/o court involvement? Y / N

FINANCIAL INFORMATION:

Primary Income Source: ○Disability ○Employment ○Public Assistance ○Retirement/Pension ○None ○Other

Additional Sources of Income: ○Disability ○Employment ○Public Assistance ○Retirement/Pension ○None ○Other

SSI/SSDI Eligibility: ○Determined to be ineligible - N/A ○ Potentially Eligible ○Eligible – Receiving Benefits ○Eligible – Not Receiving Benefits

Medicare/Medicaid Eligibility: ○Determined to be ineligible - N/A ○ Potentially Eligible ○Eligible – Receiving Benefits ○Eligible – Not Receiving Benefits

Health Insurance Coverage:

○Child Welfare ○Indian Health Services ○Medicare ○Other Direct Federal ○Other Insurance ○Private – Self Paid
○HMO ○Medicaid ○No Insurance ○Other Direct State ○PPO ○Veterans Administration

Primary Source of Payment:

○Blue Cross/Blue Shield ○No Charge ○Self Pay ○State Medicaid
○EAP ○Other Source ○State Behavioral Health Funds ○State Medicare
○HMO/PPO ○Private Health Insurance ○State Children and Family Services ○Unknown
○Workers Compensation

Emergency Contact: Name _____ Relationship to Client _____ Phone _____

Client's Employer: _____ Phone: _____

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Marital Status: ○Cohabitating ○Divorced ○Married ○Never Married ○Separated ○Widowed **Veteran:** Y / N
Are services being pursued due to concerns with someone close to you (ie spouse or significant other?) Y / N
Disability: ○Blindness/Severe Vision Impairment ○No Observable Handicap or Impairment ○Deafness/Severe Hearing Loss ○Non use/amputation of limb ○Development Disability/Mental Retardation ○Non-ambulation/severe difficulties

Does client have a primary health care provider (PCP)? Y / N

Primary Care Physician:_____ PCP Phone:_____ PCP Fax:_____

Have you had a physical within the last 12 months? Y / N Year and Month last seen? _____

Height in Feet: _____ Height in Inches: _____ What is your weight? _____

Number of days within the last 30 was physical health not good? _____

Number of days in the last 30 was mental health not good? _____

Do you use tobacco? Yes / No If yes, please mark below. If No, please skip to *Current Medications*

Cigarette use per day? ○ No Use ○ Less than ½ pack ○ ½ - full pack ○ 1-2 packs ○ more than 2 packs

Chew use per day? ○ No Use ○ Less than ½ can ○Full Can ○1 - 2 cans ○ more than 2 cans

Cigar use per day? ○ No use ○1 cigar ○1 - 2 cigars ○more than 2 cigars

Pipe (tobacco) use per day? ○ No use ○ 2 fills of pipe ○ more than 2 fills

During the last 12 months, have you tried to quit smoking? Yes / No

Are you aware on the Nebraska Quit line? Yes / No Have you attempted to use this quit line? Yes / No

Current Medications (List): _____ _____

_____ _____ _____

_____ _____ _____

Adverse reactions/allergies to medication? Y / N If yes, describe _____

_____

How many Opioid pain medications are you taking (ie Vicodin, OxyContin, etc)? If unsure list 0: _____

How many non Opioid pain medications are you taking (ie Tylenol, Advil, etc)? If unsure list 0: _____

Do you attend any self help/social support groups? Y / N If yes, number of times per month _____

Are you currently experiencing any of the following medical conditions/symptoms?

Abnormal Bleeding/Bruising	Y N	Food Allergies	Y N	MRSA	Y N	STD/HIV/AIDS	Y N
Asthma	Y N	Head Injury/Concussion	Y N	Parkinson's Disease	Y N	Thyroid Disease	Y N
Autoimmune Disease	Y N	Heart Disease	Y N	Pregnant	Y N	Tuberculosis	Y N
Blood Clots	Y N	Hepatitis (specify type___)	Y N	Renal Disease	Y N	Ulcers	Y N
Cancer	Y N	High Blood Pressure	Y N	Seizure	Y N	Whooping Cough	Y N
COPD	Y N	Influenza	Y N	Shortness of Breath	Y N		
Diabetes	Y N	Liver Disease	Y N	Special Diet	Y N		
Eating Disorder	Y N	Migraines	Y N	Other Y N Explain:			

Are you receiving treatment for each of the marked conditions/symptoms? Y / N If No, describe _____

_____

Do you have a Legal Guardian? Yes No If Yes, list _____

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Number of Dependents: **(including self and spouse)**	**Annual Family Gross Income** ***(to nearest $1000):***

RESPONSIBLE PARTY: (Guarantor/Guardian Information): Parent/Guardian complete this section i*f patient is a minor*

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____ Relationship to Client: _____

Employer: _____ Phone: _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____ Copy of card on file: ○ Yes ○ No

ID #: _____ Group #: _____ Eligibility Date: _____

If Cardholder is different than Responsible Party: Last Name: _____ First: _____

Relationship to Client: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Social Security #: _____ Employer: _____ Date of Birth: _____

SECONDARY INSURANCE INFORMATION:

Name of Insurance: _____ Copy of card on file: ○ Yes ○ No

ID #: _____ Group #: _____ Eligibility Date _____

If Cardholder is different than Responsible Party: Last Name: _____ First: _____

Relationship to Client: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Social Security #: _____ Employer: _____ Date of Birth: _____

YOUTH ONLY

Days of School Missed (last 3 months): ○ 1 day every 2 wks ○ 1 day per wk ○ 1 or less days per mo.
○ 2 or more days per wk ○ Home Schooled ○ Not Enrolled

Involved with Juvenile Services: ○ Drug Court ○ Not Involved w/Juvenile Serv. ○ OJS State Ward
○ Other Court Involvement ○ Probation

Stable Environment (Legal Custody): ○ Emancipated Minor ○ Guardian ○ Parent(s) ○ Ward of the State

Receiving Professional Partner Service? Y / N **Receiving Special Education Services?** Y/ N