WILLOW SAGE SERVICES

211 S Woodruff Ste. A-3 Idaho Falls ID 83401 Phone: 208-524-4818 Fax: 208-522-6630
440 E. Clark Street Ste. A Pocatello ID 83201 Phone: 208-233-1276 Fax: 208-233-0835

Willow Sage Services
Behavioral Health Clinic

'There is no Health without Mental Health'

ANNUAL CLIENT REVIEW PACKET

(PLEASE PRINT LEGIBLY)

CLIENT CONTACT INFORMATION *(The following items apply to the CLIENT, not to the parent/guardian)*

TODAY'S DATE	
CLIENT'S FULL LEGAL NAME	
CLIENT'S DATE OF BIRTH	/ / **SOCIAL SECURITY NUMBER:**
ADDRESS	
CITY, STATE, ZIP	
PHONE NUMBER	**HOME PHONE:** **MOBILE PHONE:**
EMAIL ADDRESS	
PREFERRED COMMUNICATION	[__] HOME PHONE [__] MOBILE PHONE [__] Email [__] TEXT MSG
OK TO LEAVE VOICE MESSAGE	[__] HOME PHONE [__] MOBILE PHONE
CLIENT LANGUAGE	**PARENTS LANGUAGE:**
HOW DID YOU HEAR ABOUT US?	

CLIENT DEMOGRAPHICS *(The following items apply to the CLIENT, not to the parent/guardian)*

ADMISSION STATUS:	[___] VOLUNTARY [___] COURT ORDERED [___] MALE [___] FEMALE [___] OTHER	
MARITAL STATUS (CLIENT)	[___] Married [___] Divorced [___] Separated [___] Never Married [___] Other	
SCHOOL:		**GRADE:**
NOTE: *We will need copies of: IEP or "504 Plan," School Psychological report, Positive Behavioral Support Plan, etc.*		
CLIENT'S EMPLOYER		
CLIENT'S EMPLOYER'S ADDRESS		**PHONE:**
CLIENT'S ETHNICITY / NATIONAL ORIGIN	[___] Caucasian (White) [___] African American [___] Native American(Tribal) [___] Asian [___] Hispanic/Latino [___] Other:	
CLIENT'S RELIGIOUS / SPIRITUAL PREFERENCE		

EMERGENCY / GUARDIAN INFORMATION

EMERGENCY CONTACT	**PHONE:**
PARENT / GUARDIAN NAME	
PARENT / GUARDIAN DOB	/ / **PARENT / GUARDIAN SS #:**
PARENTS' MARITAL STATUS	[___] Married [___] Divorced [___] Separated [___] Never Married [___] Other
NONCUSTODIAL PARENT	
MAILING ADDRESS	**PHONE:**
To provide services to children or adults with guardians, we must have current copies of custody orders, parenting plans, orders of protection, guardianship orders, powers of attorney or other documents bearing on legal custody, decision-making, etc.	

INSURANCE INFORMATION *(Copies of insurance cards and Photo ID are required)*

Primary Insurance		**Secondary Insurance**	
Company Name		**Company Name**	
Policy Number		**Policy Number**	
Employer / Group		**Employer / Group**	
Insured Name		**Insured Name**	
Insured Date of Birth		**Insured Date of Birth**	
Relation to Client		**Relation to Client**	
Sliding Scale / Copay		**NOTE**: Medicaid is always considered secondary coverage	

CLIENT’S CURRENT BEHAVIORAL AND MEDICAL HEALTH CARE PROVIDERS
(Medicaid clients need a current history and physical done by their PCP annually)

Primary Care (MD, DO, NP, PA)	Name:	Phone:	Last Seen:
Other Medical Provider	Name:	Phone:	Last Seen:
Specialist:	Name:	Phone:	Last Seen:
Pharmacy	Name:	Phone:	Last Seen:
Psychiatrist (MD, DO, NP, PA)	Name:	Phone:	Last Seen:
Med.Manager (MD,DO,NP,PA)	Name:	Phone:	Last Seen:
Psychotherapist / Counselor:	Name:	Phone:	Last Seen:
CBRS Provide	Name:	Phone:	Last Seen:
Case Manager / TCC	Name:	Phone:	Last Seen:
Peer/Family Support	Name:	Phone:	Last Seen:
Target Service Coordinator:	Name:	Phone:	Last Seen:
Other DD Service Providers:	Name:	Phone:	Last Seen:

CLIENTS CURRENT MEDICATIONS (It is recommend to have your pharmacy fax over your medication history)
Please take information directly from pill bottles. Include over-the-counter medications, supplements, vitamins, etc. :

Medication	Dose/Schedule	Purpose	Prescribed by

CHANGES OVER THE PAST YEAR (e.g., moves, marriages/divorces/arrests, deaths, health problems, job/school changes)

Client Questionnaire

SLEEP *(To be completed by or for all clients)*

What time do you usually go to bed?		What time do you usually get up?			
Insomnia – Do you (your child) have trouble with…	Falling asleep		Staying asleep		Early waking

Item		
Waking up screaming or in a panic	YES	NO
Waking up coughing	YES	NO
Labored breathing or pauses in breathing during sleep	YES	NO
Falling asleep during the day	YES	NO
Strange noises during sleep	YES	NO

Patient Health Questionnaire (PHQ-9) *(To be completed by or for all clients)*

Over the last two weeks has the patient been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
NOTE: If you checked off any problems above, 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 ____**				

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) *(To be completed on intake by or for all clients)*

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. **For example**:		
--a serious accident or fire -- a physical or sexual assault or abuse -- an earthquake or flood --seeing someone be killed or seriously injured --a war --having a loved one die through homicide or suicide		
Have you ever experienced this kind of event?	**YES (Do next 5 items)**	**NO (SKIP NEXT SECTION)**
In the past month, have you… (Answer only if you responded "YES" above)		
Had nightmares about the events or thought about the event(s) when you did not want to?	YES	NO
Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	YES	NO
Been constantly on guard, watchful, or easily startled?	YES	NO
Felt numb or detached from people, activities	YES	NO
Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	YES	NO

asQ Suicide Risk Screening Tool (National Institute of Mental Health – NIMH) *(To be completed by or for all clients)*

#	Question		
1.	In the past few weeks, have you wished you were dead?	YES	NO
2.	In the past few weeks, have you felt that you or your family would be better off if you were dead?	YES	NO
3.	In the past week, have you been having thoughts about killing yourself?	YES	NO
4.	Have you ever tried to kill yourself?	YES	NO
5.	Are you having thoughts of killing yourself now?	YES	NO

Substance Use Screening Tool *(To be completed by or for all clients)*

The following questions concern information about your (or your child's) potential involvement with alcohol and other drugs during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO". Please answer every question. If you cannot decide, then choose the response that is mostly right.
When the word "drug" is used, it refers to the use of prescribed or over-the-counter drugs that are used more than the directions and any non-medical use of drugs. "Drugs" may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed, meth), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin, Oxycontin).

	Part A: During the PAST 12 MONTHS, did you?	**NO**	**YES**
1	Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)		
2	Smoke any marijuana or hashish?		
3	Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")		
4	Have you ever used tobacco in any form (e.g., cigarettes, chew, cigars)?		
5	How often do you use tobacco in any form? [___] NEVER [___] OCCASIONALLY [___] DAILY		
	Part B: CRAFFT (Children and Teens)	**NO**	**YES**
1	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
2	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?		
3	Do you ever use alcohol or drugs while you are by yourself, or ALONE?		
4	Do you ever FORGET things you did while using alcohol or drugs?		
5	Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?		
6	Have you ever gotten into TROUBLE while you were using alcohol or drugs?		
	Part C: CAGE-AID (Adults)	**NO**	**YES**
C	Have you ever felt you ought to cut down on your drinking or drug use?		
A	Have people annoyed you by criticizing your drinking or drug use?		
G	Have you felt bad or guilty about your drinking or drug use?		
E	Have you ever had a drink or used drugs first thing in the morning to steady your nerves of to get rid of a hangover (eye-opener)?		

CHILDHOOD ANXIETY (Parents complete for children 12 and younger

Is your child more shy or anxious than other children her or his age?	NO	YES
Is your child more worried than other children her or his age?	NO	YES

Adverse Childhood Experiences Scale (ACES) *(To be completed by or for all clients, regardless of age)*

1	Did a parent or other adult in the household often or very often Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	YES	NO
2	Did a parent or other adult in the household often or very often Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	YES	NO
3	Did an adult or person at least 5 years older than you ever Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	YES	NO
4	Did you often or very often feel that No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	YES	NO
5	Did you often or very often feel that You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	YES	NO
6	Were your parents ever separated or divorced?	YES	NO
7	Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?	YES	NO
8	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	YES	NO
9	Was a household member depressed or mentally ill, or did a household member attempt suicide?	YES	NO
10	Did a household member go to prison?	YES	NO

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ANNUAL CLIENT REVIEW

Intake Cover Sheet

Clients Name: ______________________________ Date: ___________________

- ❑ ANNUAL CLIENT REVIEW PACKET
  - ❑ All pages and questions are completed with/by the Client and/or Guardian
  - ❑ Copy turned in to be Uploaded into EHR
  - ❑ Copy given to Primary Therapist

- ❑ INSURANCE VERIFICATION COMPLETED
  - ❑ Copies of front and back of Insurance Cards uploaded into the EHR.
  - ❑ Eligibility confirmed
  - ❑ Prior Authorizations confirmed

- ❑ RELEASES OF INFORMATION

(must obtain appropriate consents to contact the member's behavioral health clinicians, medical physician, family/social supports, and/or agencies and other programs with which the member is or has recently been involved)

  - ❑ ROI's are completed for each individual / agency
  - ❑ ROI's are signed by the Member
  - ❑ ROI's turned in to be Uploaded into EHR or Faxed if needed

- ❑ COORDINATION OF CARE
  - ❑ ROI's sent to other providers
  - ❑ Requests for Records done
  - ❑ Copy of Medication list from Pharmacy received and uploaded into EHR

- ❑ MEDICAID ONLY (MEDICAID ADD ON PACKET)
  - ❑ All Pages Completed with/by the Client and/or Guardian
  - ❑ Copy turned in to be Uploaded into EHR
  - ❑ Copy given to Primary Therapist
  - ❑ History and Physical requested from PCP