Bridgeway Center
HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

Client ID: ___________________ DATE: ________

Insurance & Financial Information

Patient Information

Legal Name: ____ Former Names: _______________________________________
First Middle Last

Parent / Guardian Information: ____ Phone number: __________________
First Middle Last

Address: _________________________________ City: ______________________ State: _______ Zip Code: ________________

SS #: __________________________DOB: __________________________ Phone # ___________________________________

Do you have insurance?

☐No ☐Yes *If you answer yes, you must provide staff with a copy of your insurance card to ensure accurate coverage determination

Primary Insurance as listed on card:

Policy holder full name: ☐same as patient

Policy holder date of birth: ☐same as patient | Policy holder SSN: ☐same as patient

Insurance ID or Subscriber # | Group #

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐ Other____

Address: ☐Same as patient * If different from patient: ____
City: ______________________________ State: ____ Zip: ____________

Name of **Secondary** Insurance

Insurance ID or Subscriber # | Group #

Income Information

*This information is for the ***patient only***

Dependent: A person that the patient provides more than 50% of their living expenses, whether they reside in the same house or not.
Number of dependents: ____ Self____Spouse ____Children ____Others Total # of Dependents: _____
What services are you seeking: ☐Mental Health ☐Substance Use ☐BIP/Anger Mgt ☐ Other ________________

Please list the amount the patient receives from the following sources *monthly*. If patient does not receive any income from that source, please put "0."

	Individual	Household
Salary from employment		
Disability payments		
Retirement/ Pension/ Social Security Income		
Other		
Government payments (including food stamps/EBT, TANF, etc.)		
TOTAL monthly		
Total monthly x12= annual income		

Per F.A.C. 65E-14.018, you are eligible for a sliding scale fee if your household income is less than 150% of the Federal poverty income guidelines and you have no insurance or coverage plan to pay for services at BCI.

Household income means the total income of all people whose permanent address is the same as the patient's. Do not include any income from people who do not permanently reside in the home. For example, if the patient is a minor child and the mother does not reside in the same house as the child, the mother's income would not be listed.

Total monthly household income	
Household monthly X12= annual household income	
Staff use only Round up to the nearest thousand for data entry	

If patient is a minor, please indicate guardian type:

☐Biological or Legally Adopted parent
☐Foster Parent or Relative Placement by DCF (please provide copy of Shelter Order)
☐Guardian with Power of Attorney (please provide copy of your POA document)

Please note- Power of Attorney (POA) documents for minors must specifically give rights to consent to psychotropic medications in order to proceed with our Behavioral Wellness Clinic. We offer assistance with POA documents if needed.

Bridgeway Center
HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

Client ID: ___________________ DATE: ________

Client/Patient Treatment Planning Worksheet

(To be completed by client/patient)

Why are you seeking services? What problems are you having (i.e. symptom/problem inventory)?	Where do you want to be at the end of services? What results are you hoping to get out of services (i.e. long-term goals)?
☐ Feeling depressed	☐ Less depressed (get out of bed, enjoy activities) ______________
☐ Crying a lot during the week	☐ Crying spells only 1 time per week_________________________
☐ Sleeping too much or not getting out of bed at all	☐ Sleeping no more than 10 hours per night ___________________
☐ Racing thoughts, run from topic to topic and don't stop	☐ No more racing thoughts _______________________________
☐ Hearing/seeing things others can't	☐ Fewer hallucinations and 3 coping strategies to deal __________
☐ Feeling that I can't trust other people	☐ No more distrust ____________________________________
☐ Shortness of breath, can't catch my breath	☐ No more shortness of breath ____________________________
☐ Intrusive thoughts of past trauma/flashbacks	☐ Reduced intrusive thoughts to <2 per day, increase coping ability
☐ Obsessions/Feel have to do certain things or bad happens	☐ Reduce obsessive/compulsive acts <2 x's per week, < 20 minutes
☐ DCF/FFN Involvement	☐ Resolved DCF/FFN Case _______________________________
☐ Easily distracted, unable to focus/concentrate	☐ Learn 2-3 activities to assist with focus / concentration_________
☐ Relationship problems/unable to keep/maintain friends	☐ Increase ability to communicate needs, desires, concerns_______
☐ Issues with friends due to gaming, FB, on-line excessively	☐ Limit computer/internet usage to 3 hours per week___________
☐ Currently in recovery/Desire to remain free from addition	☐ Found support system / maintained remission _______________
☐ I have attempted suicide / homicide	☐ No more suicide attempts and/or thoughts __________________
☐ Lack of energy	☐ More energy _______________________________________
☐ Change in weight (lost/gained 10+ lbs in last month)	☐ 5 nutritionally balanced meals & exercise 20 min x 3 per week.
☐ Thoughts of killing myself w/ plan & method week/month	☐ No more suicidal thoughts _______________________________
☐ Decreased need for sleep/Can stay up for days w/o sleep	☐ Sleeping 6-8 hours per night _____________________________
☐ Nightmares (intrusive)	☐ No more nightmares __________________________________
☐ Anxiety/nervousness/worry a lot; interferes w/ activities	☐ No more anxiety/nervousness/worry______________________
☐ Rapid heart rate	☐ Regular rate & rhythm of heart rate _______________________
☐ Social withdrawal; limited social support	☐ Engages in social activities _____________________________
☐ Anger/aggression, verbal or physical acting out	☐ Reduced episodes of anger / aggression ____________________
☐ Parent/child relational problems (boundaries, conflict)	☐ Reduced parent/ child relational problems _________________
☐ Memory problems, inability to recall recent information	☐ Improved memory ____________________________________
☐ Grief/Loss (guilt, shame, anger, sadness)	☐ Reduced grief / loss __________________________________
☐ Divorce/Separation	____
☐ Victim of abuse* Sexual/ emotional / physical	____
☐ Feeling of hopelessness/worthless	☐ Not feeling hopeless/worthless anymore ___________________
☐ Insomnia (can't fall asleep or stay asleep, not well rested)	☐ Sleeping at least 6 hours per night ________________________
☐ Inability to enjoy usual activities	☐ Experience joy in previously enjoyed activities ______________
☐ Restless	☐ No longer restless ___________________________________
☐ Extreme mood swings (extreme highs and lows)	☐ No more extreme mood swings __________________________
☐ Panic attacks/ heart pounding, sweating, shaking	☐ No more panic attacks ________________________________
☐ Phobias / Extreme fear of ___________________________	☐ Reduced phobias _____________________________________
☐ Self-mutilating behaviors	☐ No self-mutilating behaviors ____________________________
☐ Employment problems	☐ Stable employment ___________________________________
☐ Legal problems	☐ Resolved legal problems _______________________________
☐ Abusing alcohol or drugs	☐ Reduced use of alcohol / drugs. In remission. Negative UA test.
☐ Just had a baby and feeling depressed, confused, sad	☐ Reduced postpartum issues ____________________________
☐ Gambling issues (spend money I don't have on gambling)	☐ Reduced gambling and /or in remission ____________________
☐ Thoughts of harming self/others	☐ Reduce thoughts <2 per week, Learn 3 coping strategies________
☐ Committed abuse* Sexual / emotional / physical	Other: ___________________________________
Other: ____	*Staff members are mandatory reporters

Bridgeway Center
HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

Client ID: ___________________ DATE: ________

What steps do you need to take to get there? (i.e. obtain short-term objectives)?	How will you know when you will be ready for discharge (i.e. discharge plan)? What services will you need at discharge?
☐ Earn GED	☐ Successful completion of treatment
☐ Earn college degree	☐ Services cannot meet client needs
☐ Obtain dependable transportation	☐ When you longer feel a need for services
☐ Obtain stable employment	☐ Referral for additional services
Other: _____________________________________	☐ Referral for Aftercare Services
Other: _____________________________________	☐ Linking to additional services
Other: _____________________________________	Other: _____________________________________
Other: _____________________________________	Other: _____________________________________
Other: _____________________________________	

What do you consider to be three (3) best things or strengths about yourself?
1.
2.
3.

Bridgeway Center
HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

Client ID: ___________________ DATE: ________

Patient Information

Patient Full Name:____ Date: _________________________
First Middle Last

Other names used (Alias):____ Patient SSN:_________________________

Patient DOB: ________ Patient Age: ________ Race: ________Ethnicity: _________ Client ID: _________________________

Address:_________________________________ City: ____________________State:_________ Zip Code: ______________

Home phone:________________________ Cell phone: ________________________ Work phone: _____________________

Email address: ___________________________________Emergency Contact: ____________________________________

If the patient is a student what school do they attend: ____

If patient is a minor, please indicate guardian type:

☐ Biological or Legally Adopted parent ☐ Foster Parent or Relative Placement by DCF (please provide copy of Shelter Order)
☐ Guardian with Power of Attorney (please provide copy of your POA document)

Please note- Power of Attorney (POA) documents for minors must specifically give rights to consent to psychotropic medications in order to proceed with our Behavioral Wellness Clinic. We help with POA documents if needed.

Please indicate if any of the following apply to the PERSON SEEKING SERVICES:

☐ Currently pregnant, have been pregnant in the last 12 months, or am a single female parent with children who reside with me. ☐ Admitted to a mental health hospital at least 3 times in the last 6 months. ☐ Currently using IV drugs	☐ Discharged from a state mental health facility back to the community in the last 6 months. ☐ Been diagnosed with any of the following: Major Depressive Disorder, Bipolar Disorder, Schizophrenia	☐ Discharged from inpatient mental health hospitalization in the last 30 days. Hospital Name____________ Date of Discharge____________

Are you a military Veteran? ☐ yes ☐ no **Previous Deployment?** ☐ Combat zone ☐ Non-combat zone

Marital status:

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Separated
☐ Registered Domestic Partner

Employment Information:

☐ Full Time
☐ Part Time
☐ Unemployed
☐ Retired
☐ Leave of Absence
☐ Active Military USA
☐ Unpaid Family Worker
☐ Not in Workforce- Homemaker
☐ Not in Workforce- Not authorized to work
☐ Not in workforce- Disabled not in workforce-Student

Please check highest grade completed:

☐ 1st Grade
☐ 2nd Grade
☐ 3rd Grade
☐ 4th Grade
☐ 5th Grade
☐ 6th Grade
☐ 7th Grade
☐ 8th Grade
☐ 9th Grade
☐ 10th Grade
☐ 11th Grade
☐ 12th Grade, no diploma or GED
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Professional Degree

Current gender identity:

☐ **Male**
☐ **Female**
☐ **Trans male or Trans man**
☐ **Trans female or Trans woman**
☐ **Genderqueer or Gender non-conforming**
☐ **Other**

What type of services are you seeking today?

☐ **Mental Health- Outpatient Therapy Services**
☐ **Mental Health- Medication Management**
☐ **Substance Abuse**

Bridgeway Center
HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

Client ID: ___________________ DATE: ________

Community Involvement: How many times in the last 30 days have you attended a community-based self-improvement group? _____

Current Students: **(Average of 20 days per month during school year):** Number of School Days Available in last 90 days: ________
Number of School Days Attended in last 90 days: ________

Number of arrests in the last 30 days: _________

Residential Status/Living Arrangement: Please check one:

- ☐ **Independent- Living alone** (Patient pays 100% of their living expenses)
- ☐ **Independent- Living with non-relatives** (Patient pays their own expenses but lives with someone who is not a family member.)
- ☐ **Independent- Living with relatives** (Patient pays their own expenses but lives with a family member.)
- ☐ **Foster Care or Foster Home**
- ☐ **Group Home**
- ☐ **Residential Treatment Facility**
- ☐ **Dependent- Living with relatives** (Patient does not pay any expenses and lives with a family member.)
- ☐ **Dependent- Living with non-relatives** (Patient does not pay any living expenses and lives with someone who is not a family member.)
- ☐ **Homeless** (If patient is staying with friends or family in a home that is not their own, does not pay any expenses, patient is Dependent- Living with relatives or non-relatives, not Homeless.)
- ☐ **Department of Juvenile Justice Facility**
- ☐ **Assisted Living Facility (ALF)**
- ☐ **HUD/ Section 8**
- ☐ **Crisis Shelter**

Please check all that apply for which the person who is seeking services needs an interpreter or accommodations:

- ☐ Visually impaired
- ☐ Developmentally Disabled
- ☐ Non-Ambulatory
- ☐ Hearing Impaired
- ☐ English Severely Limited
- ☐ Physically Disabled

For appointment reminders, please select an option:

- ☐ Provide appointment reminders by calling my home phone
- ☐ Provide appointment reminders by calling my cellphone
- ☐ Provide appointment reminders by sending a text message to my cellphone
- ☐ Provide appointment reminders by sending an email link to my email address as listed above
- ☐ Do not provide any type of appointment reminders

For patient surveys, please select one option:

- ☐ Send a link to the survey in a text message to my cellphone
- ☐ Send a link to the survey in an email to my email address as listed above
- ☐ Do not send me any electronic surveys

You have the right to revoke this consent for electronic communications and surveys at any time. BCI has a non-retaliation policy and your revocation of this consent will in no way impact your treatment or access to services. Please speak to any BCI staff if you wish to revoke your authorization for electronic communication or survey.

Client ID: ___________________ 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	Several Days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge.	0	1	2	3
Not being able to stop or control worrying.	0	1	2	3
Worrying too much about different things.	0	1	2	3
Trouble relaxing.	0	1	2	3
Being so restless that it's hard to sit still.	0	1	2	3
Becoming easily annoyed or irritable.	0	1	2	3
Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total score of all columns: _______

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

Columbia-Suicide Severity Rating Scale

	During the past month?	**Yes**	**No**
1	Have you wished you were dead or wished you could go to sleep and not wake up?		
2	Have you actually had any thoughts of killing yourself?		
3	Have you been thinking about how you might kill yourself?		
4	Have you had these thoughts and had some intention of acting on them?		
5	Have you started to work out or worked out the details of how to kill yourself?		
a	Do you intend to carry out this plan?		
6	Have you ever done anything, started to do anything, or prepared to do anything to end your life?		
a	How long ago did you do any of these things?		
	In the last 3 months		
	Between 3 and 12 months ago		
	More than 12 months ago		
b	Did you receive medical treatment as a result of anything you have done to end your life?		
	In the last 3 months		
	Between 3 and 12 months ago		
	More than 12 months ago		

Bridgeway Center
HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

Client ID: ____________________________DATE: ______________

Find Your ACE Score

While you were growing up, during your first 18 years of life:

	Score yourself 1 for each YES answer	**Score**
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?	
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?	
3	Did an adult 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?	
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?	
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?	
6	Were your parents ever separated or divorced?	
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?	
8	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	
9	Was a household member depressed or mentally ill, or did a household member attempt suicide?	
10	Did a household member go to prison?	
	Total Score	

Bridgeway Center
HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

Client ID: ______________________________DATE: _______________

Treatment History

Are you currently seeing a mental health professional? ☐Yes ☐No	
If so, who?	Location?

Have you been hospitalized for emotional difficulties before? ☐Yes ☐No	
If so, when?	Where?

If you answered Yes to either of the above questions - Please complete an Authorization to Release Protected Health Information for current and previous treatment providers. Thank you

Psychiatric Medication History								
Are you currently taking or have ever taken any psychiatric medications? (If yes, please complete)						Yes		No
Type or Name of Medication	Dose	Prescribing Physician	Reason for use	Dates taken	How did this work for you?			

Current Medications				
Type or Name of Medication	Dose	Prescribing Physician	Reason for use	How long have you been on this medication?