Justice Behavioral Health Services, LLC • 3701 Union Dr., Ste 100 • Lincoln, NE 68516
Phone: 402-875-9270 • Fax: 402-875-9272

Patient Name: ______________________________ DOB: ___/___/___ Today's Date: ___/___/___
Address: __________________________________ City: __________________ ST: ______ Zip: __________
Mailing Address: ___________________________ City: __________________ ST: ______ Zip: __________
Home Phone: ____________________ Cell Phone: _____________________ Work: ___________________
Check Appropriate: ____ Minor ____ Single ____ Married ____ Separated ____ Widowed
Social Security Number: _________________________ Email: _____________________________________
Would you like to sign up for our patient portal? ________ Yes ________ No (Must give email for Yes)
Reminder Call Preference: ___ Call/Voicemail ***OR*** ___ Text ___ Email Select One: □Male □Female
If patient is a full-time student, name of school: ______________________, City/State ____________

Guarantor/Spouse/Parent/Other Relationship to Patient Information:
Name: ___________________________________ Relationship to Patient: ______________________
DOB: ___/___/___ Social Security Number: ____________________ Phone: ___________________
Mailing Address: ____________________________ City: _________________ ST: ______ Zip: __________
Email Address: ____

Emergency Contact Name: ________________________________ Phone: __________________________
Address: _____________________________________ City: _______________ ST: ______ Zip: __________

Insurance Information: Please present all insurance cards to receptionist if haven't already.
Do you have Medicare? ______ Yes ______No Do you have Medicaid? ______ Yes ______ No
Insurance Company: ___________________________ Subscriber's Name: __________________________
Subscriber's Relationship to Patient: ________________________________ DOB: ___/___/___
Subscriber's Social Security Number: ________________________________ Phone: _________________
Do you have additional insurance? ________ Yes ________ No (If Yes, please list below)
Insurance Company: ___________________________ Subscriber's Name: __________________________
Subscriber's Relationship to Patient: ________________________________ DOB: ___/___/___
Subscriber's Social Security Number: ________________________________ Phone: _________________

Authorization and Release

I certify that the information provided above is true and correct to the best of my knowledge and belief. I authorize the provider to release any information including the diagnosis and the records for any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the providers office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill services. I understand I am responsible for all co-pays, deductibles, co-insurance and balances. I understand and agree that I am ultimately responsible for any unpaid balances. I understand and agree that any cellular or landline phone numbers provided by myself to this office and to any of our service providers may leave messages for me manually and by using automatic systems such as by artificial prerecorded voice. I also agree that this office and any service providers may contact me by sending a text message and/or email to any number or email address I provide to this office or service providers and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

X____
Signature of Patient/Parent or Guardian if Minor

If available, you can email completed paperwork in to admin@cheneypsych.com

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Consent for Treatment

I, ______________________________, give my consent to Katie Hunsberger, PhD to provider
(Patient's Name)
mental health services to me; or I, ____________________________, give my consent for treatment for
(Parent/Legal Guardian's Name)
the named patient.

I Understand the Following:

- The clinician I am seeing is an independent contractor, not an employee of Cheney Psychiatric Associates, LLC.
- While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling/therapy. I realize that particular results cannot be guaranteed.
- Counseling/Therapy may escalate my emotional, mental, and physical issues. I may experience new stressors during treatment and while attempting to make life changes.
- The clinician is not providing an emergency service; I will contact the nearest hospital in case of an emergency during weekend and evening hours.
- Regular attendance will assist in maximum benefits. I have the option to discontinue treatment at any time. If I decide to discontinue treatment, I will notify the clinician in advance so that effective planning or continued care can be implemented.
- Conversations with my clinician will remain confidential; with the exception of reporting actual suspected child or elder abuse to appropriate authorities, and to protect anyone I may threaten with violence, harmful or dangerous actions (including self-endangerment). The clinician required by law, and has legal responsibility, to report unlawful actions if situations cannot be resolved.
- Self-Pay 10% Discount applies to payment on day of service only. Self-Pay Rates are $225.00 for the Initial Evaluation and $130.00 for any Follow-Up Visits.
- Copays must be paid prior to visit. All balances should be paid within thirty days of receipt of statement. I understand that I am responsible for any fees that are not paid by my insurance company. It is my responsibility to check with my insurance to check with my insurance company whether these services are covered. I understand I may have a deductible which is also my responsibility as a patient.
- I understand that I am responsible for contacting the clinic at least 24 hours prior to my scheduled appointment. I understand that my "No Show/Late Cancellations" may result in my being charged the appropriate fee of $50.00 and/or being discharged from care.
- Should telephone contact with my provider be necessary your provider or nurse will respond as rapidly as possible. Calls must address immediate need for help and not substitute an office visit. I understand I may be billed for telephone calls as insurance does not cover these expenses.
- I authorize a "Reminder Call" being made 24-48 hours prior to my scheduled appointment.
- I hereby acknowledge that I have read and understand the Patient's Rights and Responsibilities Notice of Privacy Practices (HIPAA) and Psychiatric Advance Directives (PAD). And upon my request, I have received copies of these documents.

Patient or Parent/Legal Guardian's Signature	Date

Psychosocial History Questionnaire
Justice Behavioral Health Services, LLC

Name:____ Today's Date:__________________

Person Completing This Form (if different than patient):__________________________________

Date of Birth:____________________ Place of Birth:________________________ Age:________

Presenting Issues: Briefly describe the MAIN concern(s) which brought you to the office:

____

____

Please Indicate Who Referred You Here (or if you were self-referred) and the reason for the referral:

____

____

How Long Has This Been Going On? ____

Does anything make this condition better? □ Yes □ No If YES, please explain:

____

Does anything make this condition worse? □ Yes □ No If YES, please explain:

____

Have you had other treatment/seen other providers for this condition? □Yes □No If Yes, please explain:

____

TREATMENT	Effect	Provider
□ Biofeedback ________		
□ ECT (Electroconvulsive Therapy) ________		
□ Medication Therapy ________		
□ Therapy/Counseling ________		
□ Other ________		
□ Other ________		

Are you experiencing any of the following depressive symptoms?

Symptom	Not at All	A Little	A Lot	Almost Always	Always
□ Feeling down most every day	□	□	□	□	□
□ Loss of pleasure in almost all things	□	□	□	□	□
□ Significant changes in appetite/weight	□	□	□	□	□
□ Over sleeping or under sleeping	□	□	□	□	□
□ Over activity or under activity	□	□	□	□	□
□ Loss of energy	□	□	□	□	□
□ Feelings of worthlessness/hopelessness	□	□	□	□	□
□ Diminished ability to concentrate/focus	□	□	□	□	□
□ Recurrent thoughts of death	□	□	□	□	□

Psychosocial History Questionnaire
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Are you experiencing any of the following anxiety symptoms?

Symptom	Not at All	A Little	A Lot	Almost Always	Always
□ Restlessness	□	□	□	□	□
□ Easily Fatigued	□	□	□	□	□
□ Difficulty concentrating/ easily distracted	□	□	□	□	□
□ Disrupted Sleep	□	□	□	□	□
□ Mind goes blank/memory problems	□	□	□	□	□
□ Irritability	□	□	□	□	□
□ Muscle tension and/or headaches	□	□	□	□	□
□ Worry	□	□	□	□	□

Patient/Family Mental Illness Have you had previous mental health treatment? □ Yes □ No

If YES, check all that apply: □ Hospitalization □ Intensive Outpatient □Therapy/Counseling □Medication □ Other

Dates of Treatment & Providers: ____________________

What was most effective? ____________________

What was least effective? ____________________

Do you have any family history of mental health problems? □ Yes □ No

If Yes, please explain: ____________________

____

Patient/Family Substance Use

Check all that currently apply: □ use alcohol □ use street drugs □ misuse prescription drugs □ none of these

Check all that apply to use of alcohol and/or drugs:

□ use more than intended
□ efforts or unsuccessful attempts to reduce use
□ craving or use to use
□ continued use despite problems
□ use that interferes with functioning
□ alcohol/drug related problems
□ increased tolerance
□ withdrawal spells
□ blackouts

In the past have you abused substances? □ Yes □ No

If YES, please explain: ____________________

If YES, did you receive substance abuse treatment? □ Yes □ No

If YES, when and where: ____________________

Do you have a family history of substance abuse problems? □ Yes □ No

If YES, please explain: ____________________

Have you engaged in the following activities?

□ hoarding □ unhealthy eating □ binging/purging □excessive shopping □ gambling

Explain: ____________________

____

Psychosocial History Questionnaire
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Development to Your Knowledge:

- Did your mother have any health problems or use drugs, alcohol, or smoked while she was pregnant with you? □ Yes □ No
- Did you achieve developmental milestones at the appropriate ages (i.e., crawling, walking, talking)? □ Yes □ No

Medical/Health History

Please list all medical conditions diagnosed and/or being treated for: ____________________

____

____

Any history of major surgeries & date(s): ____________________

____

Any history of head trauma, concussions, and/or major motor vehicle accidents and date(s): __________

____

____

Allergies: □ Yes □ No If YES, please list to which medication(s) & effect(s): ____________

____

Do you have chronic pain issues? □ Yes □ No If YES, please explain: ____________________

____

How do your medical problems affect your mental health? ____________________

____

____

Please list significant family medical history: ____________________

____

Family

Please list family members you grew up with (parents, extended family, siblings – and birth order): __________

____

____

Briefly describe the household you grew up in (discipline; atmosphere; who lived with; relocations; parental divorce; etc.): ____________________

____

____

Please list your parents' occupations: ____________________

Current type of housing you reside in & who lives with you: ____________________

____

Please check your marital status: □ Single □ married □ partner/significate other □ divorced □ separated □ widowed

Please list any children & their ages: ____________________

History of Trauma – In order to better understand your prior experiences, have you ever witnessed or personally experienced:

□ illness/disease	□ bullying	□ combat	□ violence in the home
□ natural disaster	□ neglect	□ fighting	□ physical abuse
□ refugee status	□ accident	□ rape	□ sexual abuse
□ verbal/emotional abuse	□ other:		

Psychosocial History Questionnaire
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If YES to any of the previous section, please check any of the following responses that you have experienced as a result:

☐ problems with sleep	☐ nightmares	☐ difficulties concentrating	☐ memory loss
☐ relationship problems	☐ flashbacks	☐ self-injurious behaviors	☐ easily startled
☐ thoughts of suicide	☐ changes in appetite	☐ avoidance of people/situations	Feeling detached from others
☐ use/abuse of substances	☐ anger/aggression	☐ disruption in thoughts/activities	☐ changes in self-care

☐ other: ______________________________

____

____

Please note what may help you feel more physically and emotionally comfortable/safe: ____________

____

Academic – Regarding your education, please list the degree(s) obtained and at what age or year:
☐ stopped school in ________ grade ☐ high school graduate _______ ☐ GED ________
☐ college (degree, area of study, & age obtained/year) ______________________________
☐ other certifications/licenses ______________________________

Please describe how you were as a student: ______________________________

____

Did you receive any special education services in school? ☐ Yes ☐ No
If YES, what type & how long: ______________________________

____

Social – Who is your social support system? ______________________________
Do you use your support system? ☐ Yes ☐ No Is your support system adequate? ☐ Yes ☐ No

Recreation & Leisure
What are your interests/hobbies? ______________________________

____

Are you happy with how you spend your free time? ☐ Yes ☐ No
If NO, what gets in the way? ______________________________

Work/Military History Are you currently employed? ☐ Yes ☐ No
If YES, where & for how long? ______________________________
Are you on disability? ☐ Yes ☐ No
If YES, what is the reason for disability & when did it begin? ______________________________

____

____

Have you served in the military? ☐ Yes ☐ No If YES, what branch & dates of service? ____________

____

Type of discharge: ☐ Honorable ☐ Other than Honorable ☐ Dishonorable
Please list any combat experience and the impact of such: ______________________________

____

Psychosocial History Questionnaire
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Financial – Please check the source(s) of your income and/or assistance you are currently receiving:

□ employment	□ social security/disability	□ veterans' benefits
□ SNAP (food stamps)	□ spouse's/partner's employment	□ spouse's/partner's disability or pension
□ pension/retirement	□ Aid to Dependent Children	□ Housing Authority
□ general assistance	□ Medicaid	□ Medicare
□ private health insurance	□ Title XX	□ other ___________________

Do you currently have financial concerns? □ Yes □ No If YES, please explain: ______________________

____

Do you currently have basic needs that are not being met? □ Yes □ No If YES, please explain: ______

____

What is your current mode of transportation?
□ driving □ rides from others □ bus/handivan □ walk/bike □ taxi □ other: _______

Legal – Have you had past/current involvement with law enforcement? □ Yes □ No
If YES, please explain: ____

____

Please check any of the following that you have engaged in or experienced:

□ domestic violence	□ violence toward property	□ violence toward others	□ road rage
□ probation/parole	□ incarceration	□ bankruptcy	□ suing other(s)
□ being sued	□ custody proceedings	□ divorce	□ mediation

□ other legal issues: ____

Spiritual/Cultural

Is spirituality and/or religion an important part of your life? □ Yes □ No
If YES, how do you practice your spiritual beliefs? ____

____

Do you consider spirituality a source of support? □ Yes □ No
Are there cultural issues currently impacting your life? □ Yes □ No
If YES, please explain: ____

____

Grief & Loss

Are you experiencing any grief/loss issues that are currently impacting your life? □ Yes □ No
If YES, please explain: ____

____

Strengths – Please list your personal strengths: ____

____

____

Goals – Please list your current goals for treatment: ____

____

____

Psychosocial History Questionnaire
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Discharge Needs Please check any of the following services that you anticipate needing after you complete your treatment here:

- ☐ psychiatrist
- ☐ support group
- ☐ therapy group
- ☐ case management
- ☐ peer support
- ☐ home care services
- ☐ group home or assisted living
- ☐ adult day care
- ☐ substance abuse treatment
- ☐ other ______________________________

Family/Other Involvement

Please list other people you would like involved in your treatment here and indicate if you agree to a signed Release of Information:

Name	Relationship	Phone Number	Release of Information
☐ ________	________	________	☐ Yes ☐ No
☐ ________	________	________	☐ Yes ☐ No
☐ ________	________	________	☐ Yes ☐ No
☐ ________	________	________	☐ Yes ☐ No
☐ ________	________	________	☐ Yes ☐ No

Please provider any other information that is important for the therapist to know about you: ________

Provider's Notes: ________

View by: ______________________________ Date: ______________

Name of Provider