La Clínica

☐ LC Transit Village ☐ San Antonio NHC ☐ Clínica Alta Vista
☐ LC Pittsburg ☐ LC Vallejo ☐ LC Monument
☐ LC Great Beginnings ☐ LC North Vallejo ☐ LC SBHC

PATIENT I.D. CARD
PATIENT NAME _____ SEX: M ☐ F ☐
MR# _____ DOB _____
PRIMARY PROVIDER _____ DATE _____

BEHAVIORAL HEALTH SCREEN (13-17)

For Office Use Only

TODAY'S DATE: ☐☐-☐☐-☐☐☐☐ (MONTH-DAY-YEAR)

AGE: ☐☐ MR#: ☐☐☐☐☐☐-☐☐

	NEVER	SOME-TIMES	A LOT	ALWAYS
Example: [X]				
1. How often do you feel nervous or unable to relax?	☐	☐	☐	☐
2. How often do you have trouble sitting still or concentrating?	☐	☐	☐	☐
3. How often you have headaches, stomachaches or sickness?	☐	☐	☐	☐
4. How often do you have trouble sleeping or do you sleep more than you think you should?	☐	☐	☐	☐
5.How often are you worried about problems at home or at school?	☐	☐	☐	☐
6. How often do you have an urge to do things over again (like washing your hands, cleaning, counting or putting things in a certain order)?	☐	☐	☐	☐
7. How often do you get more angry than you think you should?	☐	☐	☐	☐
8. How often do you and your parents/guardians have conflict?	☐	☐	☐	☐
9. How often do you feel unhappy, hopeless or tearful?	☐	☐	☐	☐
10. How often do you use alcohol or drugs to relax, feel better about yourself or fit in?	☐	☐	☐	☐

11. Do you have someone you can talk to about problems?	No ☐	Yes ☐
12. Are there conflicts in your family related to cultural differences or difficulties adjusting to life in the United States?	No ☐	Yes ☐
13. Do you ever eat in secret or control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	No ☐	Yes ☐
14. Have you ever seriously thought about running away from home?	No ☐	Yes ☐
15. Have you ever hurt yourself on purpose (by cutting, scratching, burning)?	No ☐	Yes ☐
16. Have you witnessed or overheard violence in your home or neighborhood?	No ☐	Yes ☐
17. Have you ever carried a gun, knife or club or other weapon?	No ☐	Yes ☐
18. Have you ever been physically or emotionally abused or touched in a way that was uncomfortable for you?	No ☐	Yes ☐
19. Do other people think you bully or threaten them?	No ☐	Yes ☐
20. Have you ever hit, kicked, slapped, punched or threatened your girlfriend/boyfriend?	No ☐	Yes ☐
21. Does anyone in your family drink or use drugs so much it worries you?	No ☐	Yes ☐
22. Has anyone ever told you that you should cut down on how much you drink or how much you use drugs?	No ☐	Yes ☐

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PCP Sig: _____ Date: _____ ☐ BMS Referral ☐ Decl. Ref. ☐ Not Needed ☐ F/U Screen