Phone: 402.937.8323
Fax: 402.937.8324
Website: wellspringbh.com
Address: 1600 S 70th St. Ste. 200
Lincoln, NE 68506

Registration Form

CLIENT INFORMATION			
Name		**DOB**	
Social Security #		**Phone #**	
Sex		**Language**	
Address		**Relationship Status**	
Email			

REFERRAL INFORMATION			
Name		**Relationship to client**	
Phone #		**Other**	

INSURANCE INFORMATION			
Provider		**Member #**	
Group #		**Policy Holder**	

PARENT/GUARDIAN INFORMATION	
Guardian 1	
Phone #	
Email	
Address	

Guardian 2	
Phone #	
Email	
Address	

REASON FOR REFERRAL	
Depression	Relationship Issues
Anxiety	Parent/Child Conflict
Suicidal Thought/Actions	Substance Abuse
Self-injurious Behaviors	Other
Behavioral Issues	
Please elaborate on checked items (be sure to describe symptoms, behaviors, and his/her present functioning: (use next page)	

When did these concerns begin?

CURRENT PROVIDERS	
Type	**Name**
Primary Care Physician	
Psychiatrist	
Other	
Other	

PSYCHIATRIC DIAGNOSIS Check here if there is no history of psychiatric hospitalizations	
Diagnosis	**Provider**

HISTORY OF PSYCHIATRIC HOSPITIALIZATIONS Check here if there is no history of psychiatric hospitalizations	
Date	**Reason for Admission**

HISTORY OF OUTPATIENT TREATMENT Check here if there is no history of outpatient treatment		
Date	**Provider**	**Reason for Discontinuing**

CURRENT MEDICATIONS Check here if no current medications		
Medication	**Dosage**	**Prescriber**

DEVELOPMENTAL HISTORY			
Any problems with pregnancy or birth?	Yes	No	Unknown
Any significant problems with development (walking, talking, eating, toileting, ect)?			
Yes	No	Unknown	
If yes, please describe below:			

FAMILY	
Marital Status:	
Partner's Name:	
CHILDREN	
Name	**Age**
Who currently lives in the home?	
Any family history of mental health/substance abuse concerns?	
List any important family members not living in the home:	

FAMILY MEDICAL HISTORY		
Relationship	**Major Illness?**	**Explain**
Mother		
Father		
Sibling 1		
Sibling 2		
Other significant family history of medical illness:		

FAMILY PSYCHIATRIC HISTORY	
Relationship	**Diagnoses**
Mother	
Father	
Sibling 1	
Sibling 2	
Other significant family history of psychiatric diagnoses:	

TRAUMA HISTORY Check here if there is no history of trauma		
Physical Abuse	Sexual Abuse	Emotional Abuse
Neglect	Other	
If yes, please describe:		

SUBSTANCE USE (Including alcohol and nicotine) Check here if there is no history of substance use		
Substance	**Amount**	**Frequency**
Please answer these questions if you indicated that you drink alcohol.		
Are you concerned about how much you drink?		
Are you annoyed at comments about your drinking?		

Have you felt guilty about anything resulting from you drinking?
Do you ever have a drink early in the day to calm your nerves or get rid of a hangover?
Please list the consequences related to your substance use.

MEDICAL Check here is no history of medical issues
Current Medical Concerns:
Have you had any surgeries in the past? Please provide details.
Have you ever had a brain injury? Please provider the details of that event below.

EDUCATIONAL HISTORY	
School Name	
Grade	
IEP	Yes No
Other school interventions?	

OCCUPATIONAL HISTORY		
Occupation	**Dates**	**Reason for Ending**

GOALS
Please identify treatment goals while receiving services at Wellspring