CenterPointe Outpatient Services

1000 S 13th Street Lincoln Ne, 68508 Phone (402) 475-5161 Fax (402) 475-3300

New Client Information Form

Identifying Information:

Date: ………. /……….. /………..

Legal Name: Last:________________ First:_________________ M.I.:____ Date of Birth: ___/___/ ____ Age: ____ Gender : ____

Preferred Name: ________ ____SSN#:_____ ______ _______Preferred Language: ____________ Needs Interpreter? ☐ Yes ☐ No

Primary Phone # :(____) _____ ______ Secondary Phone #: (____) ______ ______ May we send you text reminders? ☐Yes ☐No

Email: ______________________________________ May we contact you via email? ☐Yes ☐ No

US Citizen: ☐ Yes ☐ No	Veteran: ☐ Yes ☐ No
Registered to vote? ☐ Yes ☐No if no, would you like to register to vote here today? : ☐Yes ☐No	

Street Address	Apt/Unit#	City	State	Zip Code

Emergency Contact Information:

Emergency Contact: ___________________________________ Phone # :(________)_________-__________

Relationship: ____

Insurance Information:

Do you have health insurance? ☐Yes ☐No

Insurance Carrier: ____________________________________ Do you have Medicaid? ☐ Yes ☐ No

Member ID#:____ Do you have Medicare? ☐ Yes ☐ No

Current Living Situation:

Living Arrangement? (Please check at least one checkbox)

☐in your own place such as a house, apartment, or mobile home; or
☐in someone else's household; or
☐in a group care or board and care facility; or
☐in an institution such as a hospital or a nursing home

☐City Mission
☐Homeless

Where did you sleep last night? _________________

Are you currently pregnant? ☐Yes ☐No	Have you used IV drugs in the last 90 days? ☐Yes ☐No
Have you used drugs other than those required for medical reasons? ☐Yes ☐No	

Previous Behavioral Health:

Have you ever had a mental health diagnosis? ☐No ☐Yes (describe below)		
Have you ever received behavioral health services? ☐No ☐Yes (describe below)		
With whom?	When?	Type of treatment?
Have you ever been hospitalized for mental health or substance use? ☐No ☐Yes (explain below)		
When?	Where?	

Social, Educational and Work History

Marital Status:	Highest Level of Education:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Annual Income:_______________	How many Hours per week? _____
Do you drink alcohol? ☐Yes ☐No	Are you a current smoker? ☐Yes ☐No	

Name: ____________________________

Date: ___/___/_____

What brings you in today? Please check any and all applicable items below.

I am looking for services relating to:

- ☐ Therapy and counseling
- ☐ Medication management
- ☐ Inpatient treatment
- ☐ Support groups

I have been having problems with:

- ☐ Thoughts of hurting myself
- ☐ Thoughts of hurting others
- ☐ Not knowing what is real
- ☐ Thoughts of or actual relapse
- ☐ Finding good coping skills
- ☐ Intense feelings and emotions
- ☐ Hearing voices or seeing things
- ☐ Feeling afraid for my own safety

I need help with:

- ☐ Finding housing
- ☐ A deposit/first month's rent
- ☐ Getting a food box
- ☐ Applying for Medicaid
- ☐ Applying for Disability
- ☐ Applying for General Assistance
- ☐ Food stamps
- ☐ Clothing, blankets, or houseware
- ☐ Transportation
- ☐ Medical help/resources
- ☐ Finding employment

I would like to talk to someone about:

- ☐ Support for substance/alcohol use concerns
- ☐ Support for living with a mental health disorder
- ☐ Getting connected to support networks or groups
- ☐ Reconnecting with family and friends
- ☐ Dealing with loneliness and making new friends
- ☐ Relationship issues

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