UNM HOSPITALS

Child & Adolescent Walk-In Visit Information	
Full Name:	Today's Date:
Preferred Name:	Pronouns:
What can we help you with today?	
How did you hear about the walk-in clinic?	
Have you visited the walk-in clinic before? ☐ Yes ☐ No ☐ Unsure	
Did someone come with you today? ☐ Yes ☐ No If yes, are they the patient's legal guardian? ☐ Yes ☐ No	
What is the best way to contact you after this visit? Name: _____ Phone number: _____ Relationship to Patient: ☐ Patient/Self ☐ Legal Guardian ☐ Other Is it okay to leave a Voicemail? ☐ Yes ☐ No Is it okay to send a text message? ☐ Yes ☐ No	
Legal Guardian(s) ☐ Same as above ☐ Different from above Name_____ Relationship_____ Phone_____ Is it okay to leave a Voicemail? ☐ Yes ☐ No Is it okay to send a text message? ☐ Yes ☐ No	Other Legal Guardian(s) ☐ Not Applicable Name_____ Relationship_____ Phone_____ Is it okay to leave a Voicemail? ☐ Yes ☐ No Is it okay to send a text message? ☐ Yes ☐ No

If you have seen us before, you do not have to fill out the rest of the form unless there are changes	
Do you have a therapist or counselor now? If so, are they at UNMH? ☐ Yes ☐ No	Name:_____ Phone:_____
Do you have a psychiatrist now? If so, are they at UNMH? ☐ Yes ☐ No	Name:_____ Phone:_____
Do you have a primary care doctor? If so, are they at UNMH? ☐ Yes ☐ No	Name:_____ Phone:_____
If no primary care provider, would you like to establish with one? ☐ Yes ☐ No ☐ Unsure	

Medical Information (List any medical conditions we should know about)	**Medications** (List all prescribed and over-the-counter medications)

Social Determinants of Health / Well Rx

In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?	Yes	No
Are you homeless or worried that you might be in the future?	Yes	No
Do you have trouble paying for your gas or electricity bills?	Yes	No
Do you have trouble finding or paying for a ride (transportation)?	Yes	No
Do you need daycare, or better daycare, for your kids?	Yes	No
Are you unemployed or without regular income?	Yes	No
Do you need help finding a better job?	Yes	No
Do you need helping getting more education?	Yes	No
Are you concerned about someone in your home using drugs or alcohol?	Yes	No
Do you feel unsafe in your daily life?	Yes	No
Do you need help with legal issues?	Yes	No
Is anyone in your home threatening or abusing you?	Yes	No
In the last 6 months have you been to the emergency department more than twice? If Yes, how many times? _____	Yes	No
In the last 6 months, have you been hospitalized> If Yes, how many times? _____	Yes	No

Patient requested referral to:

- ☐ Community Health Worker
- ☐ Social Worker
- ☐ RN Case Manager
- ☐ Other

BEHAVIORAL HEALTH SAFETY PLAN

UNM HOSPITAL

Place Patient Label here

What makes LIFE WORTH LIVING?
UPSET BEHAVIORS: What behaviors, thoughts and/or feelings would show that I am struggling and need help?
COPING TOOLS: These are actions and activities that help decrease my stress and be less upset and stop a crisis. Can also be things that help me be more calm, happy or relaxed.
MY LIFESTYLE: These are the things that I can do regularly to help myself to be healthy – like sleep, diet, exercise, social activities, work, spiritual activities, medication and therapy.
PLAN TO MAKE MY ENVIRONMENT SAFE: These are things like securing firearms and substances, monitoring medications, adding crisis numbers to my phone, and safe places I can go (including how will I get there?)
Who are my supports? Include family, friends, school, community

Name:	Name:

MY STRENGTHS AND GOALS: What do others see in me? What do I want to accomplish right now?

Emergency Call list and Resources:	
1. Call 911 for a life-threatening emergency or request crisis intervention team (CIT)	2. NM warmline 7am-11:30 pm call, 6-11 pm text: 1-855-466-7100
3. Trans Lifeline, M-F: 877-565-8860	4. Dial 988 from any phone for MH resources, 24/7
5. National DV Hotline, 24/7: 800-799-7233	6. NM Crisis and Access Line, 24/7: 1-855-662-7474
7. UNMH psych emergency, 505-272-2920, 2600 Marble Ave. NE	

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems 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**
☐	☐	☐	☐

P-2018-150

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)