AKAIMS MINIMAL DATA SET FORMS
CLIENT INTAKE FORM

Entry of this form in the AKAIMS establishes the individual as a client. Fill in the blanks or check the boxes for each question. Do not leave anything blank. These are all required fields ("minimal data set") for the State of Alaska and continued funding is contingent upon compliance with this state requirement.

Client Profile

1. **Name (First and Last)** _____

   IF FEMALE MAIDEN NAME IS REQUIRED _____

   Name preferred to be called if different than listed on line #1 _____

2. **Client Gender:** **Female** **OR** **Male**

3. **Foster Parent Name and Number:** _____

4. **Mailing Address:** Street, Apartment _____

   City, State, Zip _____

5. **Physical Address:** Street, Apartment _____

   City, State, Zip _____

6. **Phone Number(s):** _____

7. **Date of Birth:** _____

8. **Social Security Number:** _ _ _ -- _ _ --_ _ _ _

9. **Medicaid ID Number:** _____

10. **List of persons not allowed to have contact with child:** _____

_____

Demographics

Race(s): *CHECK ALL THAT APPLY*

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Other
- ☐ Aleut
- ☐ Athabascan
- ☐ Haida
- ☐ Inupiat
- ☐ Tlingit
- ☐ Tsimshian
- ☐ Yupik
- ☐ Other Alaskan Native

Ethnicity: *CHECK ALL THAT APPLY*

- ☐ **Not Spanish/Hispanic/Latino**
- ☐ Chicano
- ☐ Cuban
- ☐ Hispanic
- ☐ Mexican American
- ☐ Puerto Rican
- ☐ Spanish/Hispanic/Latino

English Fluency: *CHECK ONE*

- ☐ Excellent
- ☐ Good
- ☐ Moderate
- ☐ Poor
- ☐ Not at all

Special Needs: *CHECK ALL THAT APPLY*

- ☐ None
- ☐ No Response
- ☐ Dev. Disabled
- ☐ Major Difficulty
- ☐ Moderate to Severe Medical Problems
- ☐ Severe Hearing Loss or Deaf
- ☐ Visual Impairment or Blind
- ☐ Other

Education: *HIGHEST LEVEL COMPLETED*

- ☐ **High School Diploma**
- ☐ **GED**
- ☐ **K – 12**
  Highest Grade Completed: _____
- ☐ **Special Education/Ungraded Classes**

INTAKE INFORMATION

1. ***Today's Date:*** __ __/__ __/ __ __

2. ***Initial Contact:*** CHECK ONE

☐ Phone ☐ Drop In ☐ Other ☐ By Appointment

3. ***City of Residence:*** CHECK ONE

☐ Anchorage ☐ Big Lake ☐ Eagle River ☐ Houston ☐ Palmer ☐ Wasilla ☐ Other: _____

4. ***Referral Source:***

☐ ASAP	☐ Private Psychiatric Hospital
☐ Alaska Native Hospital	☐ Psychiatrist or Psychiatric Outpatient Clinic
☐ Church	☐ Public Health
☐ Individual/Self-Referral	☐ School
☐ JASAP	☐ Social Services
☐ Juvenile Justice	☐ Social/Community Agency
☐ Office of Children's Services	☐ Therapeutic Court
☐ Other	☐ Youth Court
☐ Physician	

5. ***Injection Drug User (In Past 12 Months):*** CIRCLE ONE YES OR NO

6. ***Please indicate up to 3 presenting problems with number 1 being primary:***

Alcohol _____	Financial _____
Alcohol & Drugs _____	Poverty _____
Child Abuse Victim _____	Runaway Behavior _____
Coping with Daily Roles/Activities _____	Sexual Abuse Victim _____
Depression _____	Social/Interpersonal _____
Drugs _____	Suicide Attempt/Threat _____
Eating Disorder _____	Thought Disorder _____

7. ***Presenting Problem(s) in clients own words (Why are you seeking our services?):***

_____

_____

_____

9. ***Required if Female:*** Pregnant: YES OR NO If yes: DUE DATE __ __/ __ __ / __ __

How did you hear about us? (Please circle one of the following)

TV Radio Newspaper Referral from friend/agency Other

Clinician/Staff: _____ Client ID: _____ Date of Completion: _____ Intake Staff: _____

Set Free Alaska
Behavioral Health Intake Form
Child and Adolescent Outpatient Program

History of Presenting Problem

Child's Name: _____ DOB: _____ Age ____

Form completed by: ___ Parent ___ Foster Parent ___Guardian ___ Other: _____

Referred by: ___ Parent/Guardian ___ OCS ___ The Children's Place ___ Doctor
___ Other _____

Child's chief reason for needing help at this time.

_____
_____

How long has your child had these symptoms, problems or issues?

_____
_____

Has your child received treatment for these issues in the past? ___ Yes ___ No
If yes, when was the last time they were in treatment and who were they receiving treatment from?

_____
_____

Has your child ever had inpatient mental health treatment? ___ Yes ___ No
If yes, please give a brief description of treatment dates, facility name and outcomes.

_____
_____

Describe the impact your child's current behavioral/emotional struggles are having on the family.

_____
_____

Describe your child's unique qualities and strengths.

_____
_____

Is there any current legal involvement that may have an impact on your child? Please check all that apply:

_____ Custody _____ Adoption _____Probation _____ Visitation _____ Child Protective Services

_____ Other

If yes, briefly describe:

_____
_____

Behavior Checklist Please check all that apply within the past six months

Behavior	X	Behavior	X
Crying, sadness, depression		Hallucinations	
Verbalizing a wish to die		Strange or unusual behavior	
Isolation/Withdrawal		Low motivation	
Worries more than others		Twitches or unusual movements	
Nightmares, night terrors		Wanting to run away	
Bedtime fears		Sneaks out at night	
Bed wetting		Self-injuries	
Soiling (pooping) in pants		Self-induced vomiting	
Sleep difficulties, too much or too little		Binge eating	
Hyperactivity		Self-starvation	
Frequently acts without thinking		Blames others for own mistakes	
Does not finish things		Stealing	
Easily distracted		Lying	
Often caught daydreaming		Hurts animals	
Has habits or rituals		Destroys property	
Temper outbursts		Hurts people	
Irritability		Drug use	
Frequent arguing		Alcohol use	
Does things to annoy others		Tobacco use	
Anxious/Nervous		Problems with authority	
Unusual fears or phobias		Sexual Problems	

Developmental History

During pregnancy, did mother:

_____ Drink _____ Drugs _____Illness _____Accident _____Victim of Domestic Violence

_____ Pregnancy Related Problems _____ Complications with Labor/Delivery

If yes, please describe

_____

_____

Did child meet all of their developmental milestones on time?

_____ Sitting Up _____Crawling _____Walking _____Feeding Self _____Toilet Training _____Talking

_____ Dressing Self _____Sleeping Through the Night

Briefly explain any delays:

_____

_____

Medical History

Is your child currently under the care of a physician or psychiatrist? ___ Yes ___No

If yes: Doctor's Name: _____ Phone Number: _____

Treatment for: _____

Is your child currently taking any medications? ___ Yes ___No If yes, include the following information:

Names of Medications	Dosage	Prescribed by

Please indicate if your child has had any of the following: Check and describe

X	Condition	Age	Description
	Major Illness		
	Serious Infection		
	Head Injury		
	Hospitalization		
	Surgeries		
	Ear Infection		
	Poisoning		
	Allergies		
	Asthma		
	Vision Impairment (glasses or contacts)		
	Hearing		

Does your child have any other medical conditions? ___ Yes ___ No
If yes, please explain:

Are your child's immunizations up to date? ___ Yes ___ No

Does your child frequently complain of body aches and pains? ___ Yes ___No

If yes, please describe:

Does your child miss school because of his/her physical complaints? ___Yes ___No

If yes, please describe:

Interpersonal Relationships Check each item that describes your child:

	Yes	No		Yes	No
Is shy			Fights with others		
Prefers to be alone			Is demanding/bossy		
Has many friends			Bullies others		
Has a few friends			Plays with kids their own age		
Is picked on a lot			Conflicts with parents/guardian		
Is often alone, but desires friends			Poor peer relationships		
Respect for authority			Excessive conflicts with siblings		

Education

Where does your child attend school? _____

Does your child have an Individualized Learning Plan (IEP)? _____

Has your child repeated a grade? ___ yes ___ No

Does your child often get discipline referrals, or detention? ___ Yes ___No

Has your child been suspended this school year? ___ yes ___No

Family Life

Please list all of the people who currently live with your child

Name	Age	Relationship

What are your family supports? (friends, church etc.)

_____

_____

What are your family strengths?

_____

_____

Forms of discipline used in the home: _____ Time Out _____ Incentives/Rewards _____ Grounding

_____ Loss of Privileges _____ Extra Chores _____Physical/corporal punishment

Other: _____

Please list any family history of mental illness.

_____

_____

_____

Current Family Stressors Check all that apply:

Family Stressor	X	Family Stressor	X
Financial problems		Legal issues	
Divorce		Death of a relative	
Job loss		Death of a friend	
Parents using drugs/alcohol		Family illness	
Housing problems		Custody disputes	

Please list any other stressors not mentioned above.

_____

_____

_____

Emergency Contact Information

Client Name: _____

Mailing Address: _____

Physical Address: _____

Phone# _____ Cell# _____

In case of emergency Set Free Alaska Staff have my permission to notify any of the following persons':

Name: _____

Phone# _____ Cell# _____

Relationship: _____

Name: _____

Phone# _____ Cell# _____

Relationship: _____

Name: _____

Phone# _____ Cell# _____

Relationship: _____

Primary Physician: _____

Office or Business Name: _____

Address: _____

Phone# _____

By signing this I understand that I am giving Set Free Alaska permission to contact any of the persons whom I have listed above in case of an emergency

_____	_____	_____
Client Signature	Client Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Printed Name	Date

Children's Program Information

About the Therapy Process

Before starting therapy, it is necessary to understand that the therapeutic process has both benefits and risks. The very nature of therapy often involves discussing and dealing with difficult events and upsetting issues. As a result, some people may experience uncomfortable feelings such as, fear, sadness or loneliness. Additionally, there may be an increase in problem behaviors. However, research supports the benefits of therapy to both children and adolescents. While there are no guarantees about the outcomes of therapy, children and adolescents can experience a reduction in problem behaviors, increased emotional well-being and improved closeness and communication within their interpersonal relationships. During the therapeutic process the therapist will utilize individual child therapy, family therapy, social skill building, cognitive behavioral therapy, client centered therapy, and other forms of talk therapy. Additionally, the therapist will draw from aspects of both play therapy and various other expressive arts therapy.

Confidentiality

The confidentiality of all counseling interactions is protected by law. Anything you tell your therapist is considered privileged information and will be held in confidence by the therapist. Information will not be released about you to others unless you give the therapist permission to do so in writing, by signing a release of information form. There are times in which laws and professional codes of ethics require the therapist break confidentiality such instances include:

- Medical emergencies
- The existence of a threat of danger to self or others
- Reasonable suspicion of current child abuse, abandonment or neglect, dependent adult or elder abuse
- A court order or where otherwise legally required
- Third party billing claims requirements
- Receipt of a properly executed consent form
- And where otherwise legally required

Parents are encouraged to respect their minor child's right to confidentiality, in order to help the minor to feel safe and to build a trusting relationship with the therapist. Parents should be informed that in working with children/adolescents special care and sensitivity will be given to such topics as substance abuse and sexuality. The therapist may encourage the child/adolescent to share critical information and will help them to do this, with their parent/guardian, but we will not do so ourselves unless it is necessary to protect the wellbeing or life of the minor child or someone else.

**Please email or call 24 hours before the session, if you have information you want the therapist to be aware of so that she/he has time to receive the information and plan the session accordingly.*

Custody/Guardianship

•Consent for services can only be authorized by the current legal guardian. For divorced, or legally separated parents' consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. (A copy of the divorce decree must be included in the client file indicating the custodial arrangement).

•In any custodial arrangement, both parents have the right to contact the therapist and inquire regarding their child's treatment progress (unless otherwise indicated by the courts).

•As a general guideline, Set Free Clinicians will not make recommendations to the court concerning parenting issues or custody.

Client Rights (Please see Notice of Privacy Practices for procedure)

•You have the right to ask questions, refuse certain therapeutic techniques. You also have the right the right to be advised of the consequences of such refusal or withdrawal.

• You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued. If you wish, Set Free will provide you with the names of other qualified therapists.

• You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan.

• Parents have the legal right to request medical and billing records. Therapeutic treatment notes are protected by law and will not be released as a part of the treatment record.

Consent to Treatment for a Minor

• I acknowledge that I have received, read (or have read to me), and understand the information provided to me about the therapy I am considering for my child. I have had all my questions answered fully.

• I do herby consent to allow my child _____ to take part in psychotherapy with a Set Free Alaska, Clinician. I understand that a treatment plan will be developed with the therapist and a regular review of progress toward meeting the treatment goals will occur.

• I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

• I confirm that I have the legal right to consent to my child's mental health treatment without the consent of any other individuals.

• I am aware that as the parent or legal guardian I may stop treatment with the therapist at any time. The financial obligation for the services received shall fall under the responsibility of the parent who is initially seeking treatment.

• I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers or any services or treatments my child receives.

• I understand that I must call to cancel an appointment for my child at least 24 hours in advance. I acknowledge that continually showing up more than 5 minutes late for appointments or ongoing no-shows may result in my child being discharged from therapeutic services.

• I understand that the agency does not use seclusion and restraint as part of their nonviolence prevention program.

• I agree not to carry or to knowingly allow my child to carry any weapons, drugs, or drug paraphernalia within the Set Free Alaska facility.

• I understand that Set Free does not administer, maintain, or control my child's prescription medication in any manner.

• I understand that my child will participate in emergency preparedness drills as a part of the agencies health and safety program.

• I understand that in the event of an emergency the Set Free Alaska staff will direct my child in the necessary actions to be taken.

• I understand that Set Free utilizes a multi-disciplinary approach and therefore aspects of my child's treatment, and diagnosis will be discussed in treatment team meetings and with the clinical staff.

• I understand that the information the therapist gains from working with my child is confidential. With the child's permission the therapist will share information that they believe is important with his/hers parent or guardian.

• I understand that the therapist will not give information to anyone else without my written authorization.

• I understand, as the parent(s) not to request any information for court related reason whatsoever, including but not limited to custody issues.

• I understand that the role of the therapist is not to make recommendations to the judge or to express opinions concerning divorce or custody issues.

_____	_____	_____
Signature of Parent/ Guardian	Print Name	Date