FOR OFFICE USE ONLY

DATE:_____

CID_____ NEW REOPEN UPDATE THERAPIST:_____

PHONE:_____(HOME)_____(CELL)_____(WORK)

NAME:_____
LAST FIRST MIDDLE MAIDEN

ADDRESS:_____
STREET/ROUTE APT./P.O. BOX CITY STATE ZIP CODE

COUNTY:_____ DATE OF BIRTH:_____ SEX:_____

PRIMARY RACE _____ SECONDARY RACE _____ VETERAN: _____ YES _____ NO

ENGLISH PROFICIENCY _____ MOTHER'S FIRST NAME: _____RELIGION:_____

MARITAL STATUS: NEVER MARRIED____ MARRIED____ SEPARATED____ DIVORCED____ WIDOWED____

REFERRAL SOURCE:_____ LEGAL GUARDIAN'S NAME: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL:_____

ADDRESS:_____

FAMILY MEMBERS PRESENTLY LIVING IN YOUR HOUSEHOLD:

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	EMPLOYER

** IF HOMELESS, CHOOSE ONE OF THE FOLLOWING: _____ CONTINUALLY HOMELESS FOR A YEAR OR MORE
_____4 OR MORE EPISODES OF HOMELESSNESS IN THE LAST 3 YEARS ____ HOMELESS BUT 1 OR 2 NOT APPLICABLE

EDUCATION (LAST YEAR COMPLETED)_____ SPOUSE'S EDUCATION_____

YOUR OCCUPATION:_____ EMPLOYER:_____

SPOUSE'S OCCUPATION:_____ EMPLOYER:_____

ARE YOU EMPLOYED NOW? YES_____ NO_____ FULL-TIME_____ PART-TIME_____

DURATION OF EMPLOYMENT_____ TOTAL JOINT YEARLY INCOME _____

SOURCE OF INCOME _____

SOCIAL SECURITY #:_____ MEDICARE #: _____

MEDICAID #: _____ INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

E-MAIL ADRESS: _____ May we contact you at this address? YES NO

PHYSICIAN:_____ DATE OF LAST PHYSICAL:_____

ARE YOU CURRENTLY PREGNANT? ___YES ___NO PREVIOUS PSYCHIATRIC HOSPITALIZATION: _____ YES _____ NO

WHERE: _____ ADMISSION DATE:_____ DISCHARGE DATE:_____

PREVIOUS COUNSELING: ___ YES ___ NO WHERE:_____ DATES:_____

CURRENT MEDICATIONS:_____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?_____

OFFICE USE ONLY

Private Pay Means Insurance EAP

County City MAC_____

Medicare TXIX

FeeMod/ Means

CID_____ EAP

APPLE_____ MAC_____

DAKOTA COUNSELING INSTITUTE

CLIENT INSURANCE INFORMATION

Medicare Number:_____

Medicaid Number:_____

Health Insurance Company Name: _____

Insurance Company address: _____

_____

_____

Policy Number:_____ Group Number:_____

Insured's Name (Policyholder):_____

Insured's Date of Birth:_____

Insured's Address: _____

_____

I authorize my health care provider to release information requested on my insurance form. I authorize payment of any benefits directly to Dakota Counseling Institute. I understand that I am fully responsible for any charges that are not covered by my insurance policy. This authorization will remain in effect until revoked by me in writing.

Patient / Parent / Guardian Signature:_____

Updated 2017

Financial Agreement

The typical fees for service are as follows:

Outpatient Intake	$173
Outpatient Therapy	$169 - $384
Psychiatric Evaluation	$280 - $352
Medication Management	$184 - $246

These rates are subject to adjustment due to the variance in the length of sessions, intensity of service provided, and/or June 1 of each year due to contractual inflation. The typical therapeutic hour and follow-up appointments are 55 minutes. The typical psychiatric evaluation is 45-90 minutes with follow-up appointments 15-30 minutes.

Any insurance coverage or changes in coverage should be reported to the front desk. Pre-authorization of services is the responsibility of the insured. Dakota Counseling Institute is unable to guarantee payment by the insurance company due to the individuality of each plan. Denials may be due to non-covered diagnosis or other non-covered events. The agency will assist with the filing of insurance, but all charges are the responsibility of the client from the date the service is rendered. As a reminder, your insurance contract is between you, your employer when applicable, and the insurance company.

Dakota Counseling Institute will work with clients on their outstanding balances as long as the payments are reasonable and regular. We accept cash, checks, Visa and MasterCard. Returned checks are subject to an additional collection fee. Balances older than 30 days are subject to interest charges of 1 ½% per month.

I have read and understand the above information.

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Witness Date

Updated July 2019

Dakota Counseling Institute, Inc.
About Our Notice of Privacy Practices

In compliance with the law, we are committed to protecting your personal health information.

The attached Notice of Privacy Practices state:

- Our obligation under law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this Notice and to obtain your written acknowledgment that you have received a copy of this Notice.

Patient Acknowledgment of Receipt

I, _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices at Dakota Counseling Institute.

_____

Client Date

_____

Parent/Guardian Date

Documentation of Good Faith

___ Attempted to distribute the Notice of Privacy Practices to the client/parent/legal guardian, but they declined to acknowledge receipt.
___ The Notice of Privacy Practices was mailed to the client/parent/legal guardian.
___ Other _____

_____

Staff Member Date

Updated 2017

DAKOTA COUNSELING INSTITUTE
TREATMENT CONTRACT

The following is a contract between Dakota Counseling Institute professional staff and you, the consumer, to provide treatment to you. By signing this contract, both parties acknowledge that they have read, understand and agree with the terms set forth in this document.

Informed Consent: By signing this contract, you give consent to receive treatment by DC Institute professional staff. You have a right to be informed of your diagnosis. You have the right to receive information about the nature, purpose, and risks of any tests, treatment, or procedures suggested to you. You are encouraged to ask the clinician working with you any questions you may have regarding your treatment and its potential outcome. If your treatment involves individual, group, couple, or family therapy sessions, you must understand that the issues, which brought you to seek therapy, may become worse before they get better. For example, you may feel more anxious or depressed in the beginning phases of treatment. In rare cases, you may experience loss of contact with reality, or you may experience strong suicidal intent, both of which could necessitate a period of hospitalization in a psychiatric facility. During the course of therapy, interpersonal relationships may change. If you have experienced significant trauma at some time in the past, you may experience flashbacks or a reliving of past experiences and feelings associated with these.

Confidentiality: Confidentiality means that the information you share with DC Institute and its employees will not be released to other individuals or outside agencies, with the following exceptions:

1. If you sign a release specifying to whom the information is released, what information you want released, and for what time period the release of information is valid.

2. Some insurance companies and EAP's request information about your treatment. When you sign on with an insurance company and/or EAP, you sign a waiver or a release of authorization for such information. Therefore, we will release the requested information to your insurance company and/or EAP unless you inform us in writing that you do not want us to do this. Once we receive your request in writing, all information gathered about you after the request is received will not be released to your insurance company and/or EAP. However, if you make such a request, you become solely responsible for the cost of your treatment.

3. Upon a proper court order, your records and/or the testimony of your primary mental health professional may be released.

4. All mental health professionals are mandated reporters. This means that the clinician working with you has to report child abuse or abuse of other dependent persons. **This process will follow all guidelines set forth by State Law.**

5. If your primary mental health professional judges you to be a danger to yourself or others and you refuse voluntary hospitalization, necessary information will be released to outside agencies to insure your and others' safety and to insure continuity of treatment. **This process will follow all guidelines set forth by State Law.**

6. Your financial obligation, name and address may be referred to outside collection agencies, including small claims court, if your account is delinquent.

7. Contact with your HMO for coordination of care.

8. If you are under the age of 18, or have a legal guardian, your parents/legal guardians have the right to obtain information about your treatment, and the right to sign releases of information to other agencies about your treatment on your behalf.

9. If you are a parent bringing your minor child for treatment, please be advised that all information requested by or shared with one parent will also be made available to the other parent, unless such parent's rights have been terminated by a court of law and such termination order has been placed in the child's client file.

10. If you are the partner in couple's therapy, any release of records must be approved and signed by both parties, and the information will be made available to both parties participating in these counseling sessions.

11. If services are funded, wholly or in part, through State Contract or Medicaid monies, the State of South Dakota, Division of Behavioral Health, will receive certain demographic information about you and may, periodically, review records to assure our compliance with contract

requirements. At no time will we release your name or your address. If you have further questions about this, please ask staff.

12. If you receive services from more than one professional staff member of Dakota Counseling Institute, members of your treatment team will likely exchange information in order to coordinate services and provide you with the best treatment available.

Grievance Procedure: Dakota Counseling Institute is committed to providing high quality mental health services through its various programs. Our goal is to provide the most effective services possible, and we want you to be satisfied with the services you receive. As is the case with any service provider, however, occasionally there will be times when a person receiving services is dissatisfied with the services provided by the agency. If you believe that you have a legitimate complaint regarding services provided to you, please try to discuss the situation or the nature of your dissatisfaction with the staff member providing services to you. Most problems are likely to be resolved at this level.

If the problem is not resolved by talking directly to the staff person providing services to you, you may submit a written explanation of your complaint to the Clinical Director of Dakota Counseling Institute. The Clinical Director will respond to your complaint verbally and in writing within 15 days of receiving it. If the problem is not resolved at this level, you may forward your complaint in writing to the Executive Director of Dakota Counseling Institute. The Executive Director will respond to your complaint verbally and in writing within 15 days of receiving it.

If you and the Executive Director do not resolve the problem to your satisfaction, you may contact the Division of Mental Health at the following address and phone number:

Department of Social Services
Division of Behavioral Health
700 Governor's Drive
Pierre, SD 57501-5070

Phone: (605) 773-3123
Fax: (605) 773-7076

I have read this treatment contract and agree with the terms set forth in this document.

_____ _____
Client Date

_____ _____
Parent/Guardian Date

_____ _____
Witness/Therapist Date

Parental Consent: I, _____ parent/legal guardian of _____, hereby consent to have this child treated by Dakota Counseling Institute professional staff.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness/Therapist Date

(Please initial)

_____ I have been provided with a copy of the Consumer's Rights.

[Updated 2017]

Dakota Counseling Institute
Client Rights

As a client of Dakota Counseling Institute, your rights include, but are not limited to the following:

- The right to confidentiality and privacy of all medical records and information given in treatment.
- The right to be treated with respect and dignity.
- The right to receive treatment that is sensitive to you as an individual in a non-discriminatory manner.
- The right to actively participate in your treatment plans as well as any modification of that plan to insure your understanding and agreement with this plan.
- The right to know the reasons why a particular treatment is considered appropriate.
- The right to refuse any proposed treatment or medication unless in an emergency.
- The right to receive an explanation of diagnosis and prescribed medications and any side effects.
- The right to be fully informed of the fees for therapy.
- The right to locate alternative sources of assistance.
- The right to be informed of the volunteer or student status of a therapist.
- The right to review your case records unless conditions arise as specified by South Dakota Codified Law.
- The right to assert grievances if your rights are violated.
- The right to have a copy of all paperwork and notices signed and/or initialed and to receive a copy of the clients' rights and responsibilities in writing, or in an accessible format, during the intake process and be able to discuss the rights and responsibilities with DCI staff.
- The right to have access to advocacy services at any time.

To maximize beneficial consumer outcome, clients should be aware of their responsibilities.
The client is responsible for:

- Following recommended and agreed upon treatment plan
- Financial obligations of mental health services
- Punctuality of appointments and notification to center if unable to attend a session
- Consideration of the rights of the staff and other clients
- Being respectful of the property of others
- Maintaining cleanliness and order
- Providing accurate medical and personal information

Signature of Client/Parent or Guardian Date

Please fill out first and give to your provider during the appointment

Patient Name: _____ DOB:___/___/___ Date: _____

Who referred you here?_____

What are your current symptoms or concerns?

_____

_____

Please list ALL of your current medications and dosages that you are taking as well as any side effects that you are experiencing.

_____

_____

_____

Have you seen a psychiatric provider in the past? If so, who did you see and when did you see them?

_____

_____

Have you seen a therapist or counselor in the past? If so, who did you see and when did you see them?

_____

_____

Have you been hospitalized for psychiatric concerns or gone to treatment in the past? If so when and where did you go? _____

_____

Please list any medications that you have taken in the past and their effects.

_____

_____

_____

Who is your primary care provider (i.e. where you go for physical illness), and when was the last time you were seen by them?_____

Please check if you have any of the following chronic health conditions:

☐Asthma ☐Seizures ☐ Diabetes ☐High Blood Pressure ☐High Cholesterol

☐Thyroid problems ☐Cardiac problems ☐Chronic Pain ☐Other:_____

Please list any surgeries, hospitalizations, sleep study: _____

_____

Are you allergic to any medications, foods, or have any environmental allergies? If so what and what kind of reaction?_____

_____

Are your immunizations up to date? **Y / N**

Females Only:

Are you pregnant? **Y / N** If yes who is your provider? _____ Are you breast feeding? **Y /N**

How many times have you been pregnant?_____How many births?_____

Do you use a form of birth control? **Y / N** If so, what?_____

NEXT PAGE

Please fill out first and give to your provider during the appointment

Is there anyone in your immediate family with a mental illness or substance abuse problem? If so, who and what? Please list any medications that you know they are taking.

_____

_____

Where were you born?_____ Where were you raised?_____
How long have you lived at your current address and who lives with you?_____

_____

Do you have a religious, spiritual, or cultural preference? If so, please list. _____

_____

Do you work? If so, where and what do you do?_____
Are you in school? If so, where and what grade?_____
What is you highest level of education that you completed?_____

What is your family of origin (i.e. who raised you, how many siblings, ect)?

_____

_____

Are you currently married? If so, for how long? _____
Any previous marriages?_____
Do you have any children? If so, please list age and sex._____

_____

Do you drink alcohol? If so, how often and how many do you drink? _____
Do you use drugs? If so, what drugs and how often do you use? _____
Do you use any tobacco products? If so, what kind and how much do you use in a day?

_____

Do you drink caffeinated beverages (i.e. soda, coffee, tea, or energy drinks)? If so, what kind and how many of each do you drink in a day? _____

_____

Has there been any physical, emotional, or sexual abuse in the past? **Y / N**

Do you have any legal offenses or charges? If so, please list. _____
Has CPS been involved? If so, what is the name of the case worker?_____
Is there any history of disability? _____
Are you your own legal guardian? If not, please list name of guardian._____

What do you need to feel healthy and safe?_____
What are your treatment goals and preferences? _____

_____

What pharmacy do you use?_____

Adult ADHD Self-Report Scale (ASRS) Symptom Checklist

Name	Today's Date

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never 0	Rarely 1	Sometimes 2	Often 3	Very Often 4
1. How often do you make careless mistakes when you have to work on a boring or difficult project?					
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
7. How often do you misplace or have difficulty finding things at home or at work?					
8. How often are you distracted by activity or noise around you?					
9. How often do you have problems remembering appointments or obligations?					

Part A

10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
12. How often do you feel restless or fidgety?					
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

TWO QUESTIONS FOR SCREENING

1. Have any of your blood relatives been diagnosed as "manic-depressive" or as having bipolar disorder?

2. Have you ever had far more energy than usual, slept very little and engaged in activities that may have been risky or dangerous?

MOOD DISORDER QUESTIONAIRE (MDQ)

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only. No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

Name		Today's Date	

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MIDLY it did not bother me much	MODERATELY it was very unpleasant but I could stand it	SEVERELY I could barely stand it
1. Numbness or tingling				
2. Feeling hot				
3. Wobbliness in legs				
4. Unable to relax				
5. Fear of the worst happening				
6. Dizzy or lightheaded				
7. Heart pounding or racing				
8. Unsteady				
9. Terrified				
10. Nervous				
11. Feelings of choking				
12. Hands trembling				
13. Shaky				
14. Fear of losing control				
15. Diffuculty breathing				
16. Fear of dying				
17. Scared				
18. Indigestion or discomfort in abdomen				
19. Faint				
20. Face flushed				
21. Sweating (not due to heat)				

BECK INVENTORY

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making a choice.

1. 0 I do not feel sad.
   1 I feel sad
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad and unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated by things than I ever was.
    1 I am slightly more irritated now than usual.
    2 I am quite annoyed or irritated a good deal of the time.
    3 I feel irritated all the time.

112. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions more than I used to.
    3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel there are permanent changes in my appearance that make me look unattractive
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than five pounds. I am purposely trying to
    2 I have lost more than ten pounds. loose weight by eating
    3 I have lost more than fifteen pounds. less. YES___ NO___

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think of anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I have almost no interest in sex.
    3 I have lost interest in sex completely.

PLEASE ANSWER YES OR NO ON THE LINE FOLLOWING EACH SENTENCE.

Do you notice that your mood and/or energy levels shift drastically from time to time? _____

Do you notice that, at times, your mood and/or energy level is very low, and at other times, very high? _____

During your "low" phases, do you often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things you need to do? _____

Do you often put on weight during these periods? _____

During low phases, do you often feel "blue," sad all the time, or depressed? _____

Sometimes, during these low phases, do you feel hopeless or even suicidal? _____

Is your ability to function at work impaired or are you socially impaired? _____

Do these low phases typically last for a few weeks, but sometimes they last only a few days? _____

Sometimes with this type of pattern, you may experience a period of "normal" mood in between mood swings, during which your mood and energy level feel "right" and your ability to function is not disturbed? _____

Do you then notice a marked shift or "switch" in the way you feel? _____

Does your energy increase above what is normal for you, and do you often get many things done that you would not ordinarily be able to do? _____

Sometimes, during these "high" periods, do you feel as if you have too much energy or feel "hyper"? _____

Do you, during these high periods, feel irritable, "on edge," or aggressive? _____

Do you, during these high periods, take on too many activities at once? _____

During these high periods, do you spend money in ways that cause you trouble? _____

Are you more talkative, outgoing, or sexual during these periods? _____

Sometimes, does your behavior during these high periods seem strange or annoying to others? _____

Do you sometimes get into difficulty with co-workers or the police, during these high periods? _____

Sometimes, do you increase your alcohol or non-prescription drug use during these high periods? _____

Now that you have read this passage, please check one of the following four boxes:

☐ This story fits me very well or almost perfectly.
☐ This story fits me fairly well.
☐ This story fits me to some degree, but not in most respects.
☐ This story does not really describe me at all.

PLEASE INDICATE WHETHER **YES** OR **NO** IS THE BEST ANSWER FOR YOU:

1. Have any of your closest relationships been troubled by a lot of arguments of repeated breakups? 1 = **YES** 0 =**NO**
2. Have you deliberately hurt yourself physically (e.g. punched yourself, cut yourself, burned yourself)? How about made a suicide attempt? 1 = **YES** 0 =**NO**
3. Have you had at least 3 other problems with impulsivity (e.g. eating binges and spending sprees, drinking too much and verbal outbursts)? 1 = **YES** 0 =**NO**
4. Have you been extremely moody? 1 = **YES** 0 =**NO**
5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner? 1 = **YES** 0 =**NO**
6. Have you been distrustful of other people? 1 = **YES** 0 =**NO**
7. Have you frequently felt unreal or as if things around you were unreal? 1 = **YES** 0 =**NO**
8. Have you chronically felt empty? 1 = **YES** 0 =**NO**
9. Have you often felt that you had no idea of who you are or that you have no identity? 1 = **YES** 0 =**NO**
10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g. repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)? 1 = **YES** 0 =**NO**

My feelings towards food and body...?

I feel out of control with my eating _____

I dislike my body _____

I am always trying to control my weight _____

I often binge eat and then try to get rid of calories _____

I skip meals to control my weight _____

I am secretive about my eating _____

I get anxious when I don't exercise _____

Others say I have lost a lot of weight in a short period of time _____

My menstrual periods are irregular or have stopped completely _____

I am scared of weight gain _____

Sometimes I vomit after eating _____

I use diet pills, laxatives or other substances to control my weight _____

I believe I am overweight even though others tell me I am not _____

I don't deserve to eat and feel guilty if I do _____

I isolate myself from others because of the way I look or because food my be involved _____

Division of Behavioral Health
Mental Health Outcome Tool
INITIAL

Todays' Date: ____/____/____

Client STARS ID: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Program: ☐ CARE ☐ IMPACT

☐ First Episode Psychosis (SEBHS and BMS Only)

☐ Transition Age Youth Receiving CARE (BMS/LSS Only) ☐ Transition Age Youth Receiving IMPACT (BMS/LSS Only)

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1. Would you say that in general your health is:

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

a. Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good? ____

b. Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good? ____

c. During the past 30 days, approximately how many days did your poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? ____

2. Please answer the following question based on the past 30 days...	Number of Nights/Times	Don't know
How many times have you been arrested? *Federally required element	____	☐

3. Please answer the following questions based on the past 6 months...	Number of Nights/Times	Don't know
a. How many times have you gone to an emergency room for a psychiatric or emotional problem?	____	☐
b. How many nights have you spent in a facility for:		
i. Detoxification?	____	☐
ii. Inpatient/Residential Substance Use Disorder Treatment	____	☐
iii. Mental Health Care?	____	☐
iv. Illness, Injury, Surgery	____	☐
c. How many times have you been arrested?	____	☐
d. How many nights have you spent in a correctional facility including jail or prisons (as a result of an arrest, parole or probation violation)?	____	☐
e. How many times have you tried to commit suicide?	____	☐

Adult MH Tool – Initial Interview

4. Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion over the past 6 months. (Please answer for relationships with persons other than your behavioral health provider(s).) Source: MHSIP Survey *Federally Required	Response Options						
	Strongly disagree	**Disagree**	**Undecided**	**Agree**	**Strongly agree**	**Not applicable**	**Refused**
Domain: Social Connectedness Questions 1-4							
1. I am happy with the friendships I have.	☐	☐	☐	☐	☐	☐	☐
2. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐	☐
3. I feel I belong in my community.	☐	☐	☐	☐	☐	☐	☐
4. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐	☐
Domain: Improved Functioning Domain: Questions 5-8							
5. I do things that are more meaningful to me.	☐	☐	☐	☐	☐	☐	☐
6. I am able to take care of my needs.	☐	☐	☐	☐	☐	☐	☐
7. I am able to handle things when they go wrong.	☐	☐	☐	☐	☐	☐	☐
8. I am able to do things that I want to do.	☐	☐	☐	☐	☐	☐	☐