

FOR OFFICE USE ONLY

CID: _____

NEW

REOPEN

UPDATE

DATE: _____

THERAPIST: _____

NAME: _____

LAST

FIRST

MIDDLE

MAIDEN

PHONE: _____

HOME

CELL

WORK

ADDRESS: _____

STREET

APT/ P.O. BOX

ADDRESS: _____

CITY

STATE

ZIP CODE

COUNTY

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ SEX _____

ENGLISH PROFICIENCY: _____ PRIMARY RACE: _____ SECONDARY RACE: _____ RELIGION: _____

MOTHERS FIRST NAME: _____ LEGAL GUARDIAN'S NAME: _____

MARITAL STATUS: NEVER MARRIED _____ MARRIED _____ SEPERATED _____ DIVORCED _____ WIDOWED _____ VETAN: YES / NO

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

BILLING 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 PAST 3 YEARS _____ HOMELESS BUT 1 OR 2 ARE NOT APPLICABLE

EDUCATION (LAST YEAR COMPLETED) _____ SPOUSE'S EDUCATION: _____ SPOUSE'S OCCUPATION _____

YOUR OCCUPATION: _____ EMPLOYER: _____ DURATION OF EMPLOYMENT: _____

EMAIL ADDRESS _____

☐ By selecting this box, you are consenting to receiving your statement and invoices electronically instead of in paper form. Please be sure to have email address and cell phone number on this form. Thank you.

TOTAL JOINT INCOME: _____ SOURCE OF INCOME: _____ EMPLOYED: FULL-TIME _____ PART-TIME _____

REFERRAL SOURCE: _____ PRIMARY PHYSICIAN/CLINIC: _____

INSURANCE/COVERAGE: _____ POLICY NUMBER: _____

PREVIOUS COUNSELING YES / NO WHERE? _____ ADMIN/DISCHARGE DATES _____

PREVIOUS PSYCHIATRIC HOSPITALIZATION? YES / NO WHERE? _____ ADMIN/DISCHARGE DATES _____

CURRENT MEDICATIONS: _____

WHOM MAY WE CONTACT IN CASE OF EMEEGENCY _____

NAME

CONTACT NUMBER

FINANCIAL ELIGIBILITY (Calendar Year 2026)

Instructions

Please read and complete all questions on this form. This information will be used to determine your eligibility for services funded by the Division of Behavioral Health.

Behavioral Health Provider Use Only

☐ **Eligible** – Annual Review Date: _____

☐ **Ineligible**

BH Provider: _____

CID #: _____

Signature: _____

Personal Information *(Please Print)*

Client Name: _____
(First)
(MI)
(Last)

Parent/Guardian or Representative (if applicable): _____

- ☐ Yes ☐ No I (SED or SUD client) have applied for and been denied Medicaid and CHIP-NM.
☐ Yes ☐ No I (SMI client) have applied for and been denied SSL.

Description of Household

Total Number of Persons Living in Household (dependent on household income): _____

Financial Information

Annual Gross Income: All sources of earned and unearned income for the household members included above. Do not include any income earned from a child under the age of 18 or any dependent attending school.

1) Earned Income (*i.e. wages*) \$ _____

2) Unearned Income (*i.e. child support, TANF, SSDI*) \$ _____

Minus Annual Deductions/Expenses:

3) \$ _____ Earned Income Deduction (*Deduct 20% of Earned Income. Do not deduct 20% from unearned income.*)

4) \$ _____ Childcare Expenses (*up to \$6,000/year*)

5) \$ _____ Child Support Payments

6) \$ _____ Annual out of pocket prescription medication costs and lab work.

7) \$ _____ Annual health insurance premiums.

8) \$ _____ Assistive devices purchased within the last 12 months.

(describe) _____

Annual Net Income:

9) \$ _____ (*deduct lines 3 through 8 from line 1 and 2*)

Household Size	Annual Income
1	\$29,526
2	\$40,034
3	\$50,542
4	\$61,050
5	\$71,558
6	\$82,066
7	\$92,574
8	\$103,082
9	\$113,590
10	\$124,098

I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report changes in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services. I understand that if I am determined eligible and my situation should change before my annual review date, it is my responsibility to notify the Behavioral Health Provider so that eligibility can be reevaluated. Eligibility could be affected by increases in income, changes in the number of persons in the household, and/or any other significant change in financial circumstance.

Signature (Client or Parent/Guardian) _____

Date _____

Dakota Counseling Institute

Summary of Client Records Release Policy

At Dakota Counseling Institute (DCI), your privacy and confidentiality are very important to us. We follow state and federal laws, including HIPAA, when sharing your records with others.

When Can Records Be Shared?

We will only share your information if:

- You give us written permission using a signed release form,
- The law requires it (for example, a court order),
- It's needed for billing or benefits and allowed by law, or
- It's needed to help coordinate your care with another provider (called continuity of care).

What You Can Request

You have the right to see or get a copy of your records. Just let us know in writing, and we'll respond within 30 days. We recommend reviewing your records with your therapist or another member of our professional staff first. In some cases, we may charge a small fee to cover printing or mailing.

What We Usually Share

With your permission, we may share things like:

- Assessments and diagnoses
- Dates and types of services
- Medications we prescribed
- Summaries of your treatment progress

We do not usually share detailed therapy progress notes unless:

- You ask for them yourself,
- An insurance company needs them to review benefits,
- You have filed for a benefit (e.g., disability, vocational rehabilitation, etc.) and detailed notes are requested to make a determination, or
- A court legally orders us to share them.

Who Might Ask for Records?

We may get requests from:

- You or your legal guardian
- Your lawyer
- Insurance companies or Medicaid
- Social Security or disability agencies
- Other healthcare providers or schools
- The Division of Behavioral Health (for things like overall numbers or demographics, but nothing that will personally identify you)

We'll only share information with those you've given us written permission to share with — unless the law says otherwise.

Have Questions?

If you have questions about your records or want to request a copy, talk to your therapist or call our office.

Updated: 06/19/2025

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, authorize DAKOTA COUNSELING INSTITUTE
(DAKOTA COUNSELING INSTITUTE 910 W. HAVENS MITCHELL SD 57301 (605) 996-9686 FAX: (605) 231-5897)

☐ Release information to: _____

☐ Obtain information from: _____

Reason for Disclosure:

- | | |
|---|--|
| ☐ Treatment planning/ coordinating/ continued care | ☐ Billing or claims |
| ☐ Evaluation/ assessment | ☐ Legal Purposes |
| ☐ Personal Use/ Self Request | ☐ School |
| ☐ Insurance | ☐ Other: _____ |
| ☐ Disability Determination | |

This information is regarding _____
(clients name)

(Social Security Number)

Date of Birth

The following information is being released/ requested (BE SPECIFIC "ENTIRE FILE" WILL NOT BE HONORED)

- | | |
|---|---|
| ☐ Psychiatric & Psychological Evaluations | ☐ Mental Health progress notes |
| ☐ Medication management notes | ☐ Educational records/ testing |
| ☐ Mental Health History/ Intake Assessment | ☐ Medical Records/ Lab Reports |
| ☐ Substance Abuse evaluation(s) | ☐ Discharge Summary/ Transfer |
| ☐ Treatment plans/ Therapy Summary/Diagnosis | |
| ☐ Other: _____ | |

Right To Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I also understand that I have the right to refuse to sign this authorization and am not required to sign this form to receive treatment or be eligible for services. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the relevant Health Insurance Portability and Accountability Act privacy rules. I understand that any revocation does not cover materials released prior to receipt of the written revocation by Dakota Counseling Institute. I understand that my records may be faxed to the requesting recipient.

Effective time period: this authorization unless revoked earlier, this authorization will be in effect for one year from the date signed. Expiration date: Month: _____ Day: _____ Year: _____

WITNESS

DATE

CLIENT

PARENT/ GAURDIAN

DATE

(NOTE: A COPY SHALL BE AS VALID AS THE ORIGINAL DOCUMENT)

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	\$236.20
Outpatient Therapy	\$107.30-\$208.80
Psychiatric Evaluation	\$265.90 - \$346.60
Medication Management	\$142.90-283.80

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 2024

**Informed Consent Form for Child/Adolescent Therapy
Separated/Divorced Parents
Dakota Counseling Institute**

As a mental health center, our responsibility and goal is the well-being of our identified clients. In the case of a child as the primary client, it is essential that parents and/or legal guardians are in agreement regarding the decision to treat, the treatment goals, appointment times and the need to maintain client confidentiality. As a result, it is the policy of Dakota Counseling Institute that all minors presented for treatment have the following authorization and consent on file:

- Both legal parents/guardians agree to the treatment and providing of mental health services for their child and will indicate their consent below. If there is a custody agreement in place, documentation of this agreement will need to be provided to the agency prior to the beginning of services. In the event that there is no documentation, both parents need to sign for authorization and consent.
- In the event that the parent presenting the child for treatment has no access to the other parent due to the following reasons (death, incarceration, missing, has left and made no contact, etc.) and therefore will acknowledge that they are the sole primary caretaker of the child for mental health treatment and will bear all responsibility for such consent.

I understand that any Dakota Counseling Institute therapist is not agreeing to be an expert witness or to testify on my behalf or on the behalf of any other individual other than my child at any deposition, court proceeding, or in any other way. Should the therapist be subpoenaed, I understand I am responsible for any costs associated with the subpoena. I understand the clinician may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding at his/her sole discretion. Dakota Counseling Institute may also charge for the receipt of any correspondence or acceptance of any telephone calls, other than those directly from the court for the child receiving treatment.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Minor Child _____ DOB: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

REGARDING SUBPOENAS AND PROFESSIONAL STAFF TESTIMONY

Occasionally, professional staff members of Dakota Counseling Institute are ordered to provide testimony in court regarding their professional contact (e.g. psychotherapy, medication management, casemanagement, psychological testing, mental health evaluation, emergency assessment) with clients. For any professional staff member to appear in court, he or she must have been served an official subpoena to appear in court on a stated date and time.

When a member of the professional staff is subpoenaed to testify regarding treatment of a current client, the staff member will discuss any possible testimony with the client at their next session. A rough outline of content of the testimony will be discussed with the client and, when possible, with the client's attorney.

Professional staff members giving testimony in court are considered expert witnesses, meaning they will be asked to give opinions and discuss hypothetical questions rather than simply asked to repeat factual data. Clients will need to be aware that their attorneys will be billed for the time professional staff are out of the office and thus unable to see other clients, whether or not they are called to testify in the end. Therefore, if, for example, a professional staff member is ordered to be in court at 9:00 am, does not testify until 11 am and then is on the stand for an hour, the attorney will be billed for three hours. Hours are billed in 30 minute increments at the psychotherapy rate valid at the time of testimony. Insurance companies, medicaid/medicare, and any other third party payors will not be billed for court testimony. You need to be aware of this as in the vast majority of cases attorneys will recover these costs from you, the client. Attorneys will also be billed for the time it takes to travel to and from the office to the court house where testimony is to be given.

By signing below, you indicate that you have read and understand the above information regarding professional staff testimony, and agree to the terms and conditions outlined above.

Client Signature

Date

Witness Signature

Date

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

DAKOTA COUNSELING INSTITUTE TREATMENT CONTRACT

The following is a contract between Dakota Counseling Institute (DCI) and its professional staff, and you, the client. This contract must be agreed to and signed in order 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 DCI professional staff, or a student or intern who is under the supervision of a licensed professional staff member. 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 involved 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. The same is true for medications if you are seeking medication management of your symptoms. All medications have the potential for side effects, and not every medication works the same for everyone. 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 DCI 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 EAPs request information about your treatment. When you sign on with an insurance company and/or EAP, you sign a waiver or a release of information authorizing 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 made 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 the 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 the 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 any 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. Similarly, if your therapist is under supervision of a licensed provider,

the supervisor will periodically review records, and you therapist may discuss your case in supervision meetings. All participants in supervision are bound by the same confidentiality standards as your therapist.

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 have a 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 Behavioral Health at the following address and phone number:

South Dakota Department of Social Services
Division of Behavioral Health
700 Governors Drive
Pierre, SD 57501

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

I have read this treatment contract and understand its terms. My signature below indicates that I 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/protected adult treated by Dakota Counseling Institute professional staff.

Parent/Legal Guardian

Date

Witness/Therapist

Date

(Please initial)

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

[Revised 5/2024]

PARENTIAL INFORMATION SHEET
Therapy 2-7 year olds

Child: _____ Today's Date: _____

Child Lives with: _____

(Name)

(Street Address)

(City/State/Zip)

(Relationship to Child)

Biological Father: _____

(Name)

(Street Address)

(City/State/Zip)

(Relationship to Child)

Biological Mother: _____

(Name)

(Street Address)

(City/State/Zip)

(Relationship to Child)

Parents are: (please check one)

- ☐ Married and living together
- ☐ Married and separated
- ☐ Legally divorced
- ☐ Not married and living together
- ☐ Not married and living separately

If divorced or living separately, (please check one)

- ☐ Both parents have legal custody
- ☐ Mothers' parental rights have been terminated
- ☐ Fathers' parental rights have been terminated

**DAKOTA COUNSELING INSTITUTE
CHILD/ADOLESCENT PARENT QUESTIONNAIRE**

IDENTIFYING INFORMATION

Child's Name: _____ Today's Date: _____
Child's date of Birth: _____ Child's Age: _____ Sex: Male ___ Female ___

PRESENTING PROBLEM

Reason for today's visit: _____

When did the problems begin? _____

PARENTS, SIBLINGS AND OTHERS IN HOME

Mother's Name: _____ Mother's age: _____
Occupation: _____ (full-time /part-time)
Education/ highest grade completed: _____

Father's Name: _____ Father's age: _____
Occupation: _____ (full-time/ Part-time)
Education/ highest grade completed: _____

Does your child have step parent's? No ___ Yes ___ (if yes please complete the following information:

Name(s): _____

Relationship(s) to child: _____
Address(es)/ Phone: _____

Is the child adopted or being raised by person other than his/her biological parents? No ___ Yes ___
If yes, please explain: _____

SIBLINGS

Name	Age	Gender	Lives at child's home	Nature of relationship with child
1.) _____	____	M/F	Yes/ No	_____
2.) _____	____	M/F	Yes/ No	_____
3.) _____	____	M/F	Yes/ No	_____
4.) _____	____	M/F	Yes/ No	_____
5.) _____	____	M/F	Yes/ No	_____

Please list any others living in the household:

Name: _____	Relationship to child: _____
Name: _____	Relationship to child: _____
Name: _____	Relationship to child: _____
Name: _____	Relationship to child: _____

FAMILY CIRCUMSTANCES

Who cares for the child when parents or caregivers are at work or gone? _____

With whom does the child currently live: _____

Are the parents divorced or separated: _____

If yes, who has custody? _____

How often does the noncustodial parent see the child? _____

How often does the child see his/her grandparents? _____

Has the family recently experienced any unusual or stressful events? No ____ Yes ____

If yes, please explain: _____

PREGNANCY

Did the mother receive prenatal care? No ____ Yes ____ if yes, what kind? _____

Length of pregnancy? _____ Length of labor: ____ (Hrs) Apgar Scores: _____

Did the mother experience any emotional or medical difficulties during the pregnancy?

No ____ Yes ____ if yes, please explain: _____

Birth weight: ____ lbs. ____ oz. Length: _____ Inches

DEVELOPMENT

Was this child breast-fed or bottle-fed? _____ Age weaned: _____

Did the child experience any of the following problems during infancy or toddlerhood? If yes, please explain.

Colic	No ____ Yes ____
Excessive crying	No ____ Yes ____
Delayed language development	No ____ Yes ____
Unclear speech	No ____ Yes ____
Eating problems	No ____ Yes ____

Delayed fine motor skills No ___ Yes ___
Delayed gross motor skills No ___ Yes ___
At what approximate age did your child begin exhibiting the following behaviors?

Crawled: _____ Sat alone: _____
Walked independently: _____ Spoke first words: _____
Spoke in sentences: _____ was toilet trained: _____

Has your child been the victim of abuse? No ___ Yes ___

If yes, please explain: _____

MEDICAL AND PSYCHIATRIC HISTORY

Name of child's primary care physician: _____

Address- _____ Phone: _____

Has your child experienced any of the following medical problems? If yes, please explain

Frequent colds	No ___ Yes ___	Vision Problems	No ___ Yes ___
Frequent ear infections	No ___ Yes ___	Does your child wear glasses	No ___ Yes ___
Asthma	No ___ Yes ___	Hearing problems	No ___ Yes ___
Gastrointestinal problems	No ___ Yes ___	Cerebral palsy	No ___ Yes ___
Muscle pain	No ___ Yes ___	Lead poisoning	No ___ Yes ___
Skin problems	No ___ Yes ___	Seizures	No ___ Yes ___
Repetitive behaviors		Congenital problems	No ___ Yes ___
(head banging, rocking etc.)	No ___ Yes ___		
Allergies	No ___ Yes ___		

Please list any other health concerns: _____

MEDICATION

Is your child currently taking any kind of medication? No ___ Yes ___

If yes, indicate name, dose, and reason for medication. _____

Is your child experiencing any side effects from the medication(s)? _____

PREVIOUS EVALUATIONS

Psychological evaluation: No ___ Yes ___ Date of evaluation: _____

Reason for evaluation: _____

Psychiatric Evaluation: No ___ Yes ___ Date of evaluation: _____

Reason for evaluation: _____

Neurological/Neuropsychological evaluation: No ___ Yes ___ Date of evaluation: _____

Reason for evaluation: _____

BEHAVIORAL SYMPTOMS

Does your child have difficulty with any of the following problems? If yes, please explain.

Has trouble meeting new people	No ☐ Yes ☐
Is shy or withdrawn	No ☐ Yes ☐
Seems sad or depressed	No ☐ Yes ☐
Has had or is having thoughts of suicide	No ☐ Yes ☐
Refuses to comply with adults request or violates parental rules	No ☐ Yes ☐
Has conduct problems	No ☐ Yes ☐
Is physically cruel to other people	No ☐ Yes ☐
Is physically cruel to animals	No ☐ Yes ☐
Is inattentive	No ☐ Yes ☐
Problems concentrating	No ☐ Yes ☐
Is restless	No ☐ Yes ☐
Makes careless mistakes	No ☐ Yes ☐
Has trouble playing quietly	No ☐ Yes ☐
Has frequent mood shifts	No ☐ Yes ☐
Frustrates easily	No ☐ Yes ☐
Has difficulty managing anger	No ☐ Yes ☐
Has difficulty expressing emotions	No ☐ Yes ☐
Has eating problems	No ☐ Yes ☐
Has fears/phobias	No ☐ Yes ☐
Has hallucinations	No ☐ Yes ☐
Has experienced trauma	No ☐ Yes ☐

Has your child ever experienced difficulty/run in with the law? No ☐ Yes ☐

If yes, please explain: _____

EDUCATION STATUS AND HISTORY

Name of current school: _____ Grade: _____

Teachers: _____

Does your child receive any special education services? No ☐ Yes ☐

If yes, please explain. _____

What grades does the child currently receive? _____

Is this a change from previous years? No ☐ Yes ☐

If yes please explain: _____

SCHOOL HISTORY

Preschool at what age? _____ For how many days/ hours? _____

Any problems? No ☐ Yes ☐ if yes, describe: _____

Does your child dislike going to school? No ____ Yes ____

If yes, why? _____

Did the child have difficulty or receive any special education services in any of the following grades? If so please explain.

Kindergarten	No ____ Yes ____
Grades 1-3	No ____ Yes ____
Grades 4-6	No ____ Yes ____
Grades 7-8	No ____ Yes ____
High School	No ____ Yes ____

What is your child's current favorite subject(s)? _____

What is your child's least favorite subject(s)? _____

What is your child's approach to his/her school work (disorganized/organized, irresponsible/responsible ect.) _____

WORK HISTORY

Does your child have a job, or involved in a vocational program? No ____ Yes ____

If yes, who is the child current employer? _____

Child position: _____ Hours worked per week: _____

EXTRA-CURRICULAR ACTIVITIES

Please list any sports, clubs, volunteering, arts, hobbies, or anything else the child is involved in.

Any additional information that you think would be helpful and/or knowledgeable for Dakota Counseling to know? _____

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only:

Severity score: _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Division of Behavioral Health
Family Mental Health Disorder Outcome Tool

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

Date: _____

Tool Type:

- ☐ Initial
☐ Update
☐ Discharge

☐ Family

1. Would you say that in general your child's mental health is:

- ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. What is your child's employment status?

- ☐ Employed full time (35+ hours per week) ☐ Employed part time ☐ Homemaker
☐ Student ☐ Retired ☐ Other (specify)
☐ Disabled ☐ Unemployed

3. Which of the following best describes your child's current residential status?

- ☐ Independent, living in a private residence ☐ Homeless ☐ Dependent, living in a private residence
☐ Residential Care (group home, rehabilitation center, agency-operated care) ☐ Foster Home/ Foster Care ☐ Institutional setting (24/7 care by skilled/specialized staff/doctors)
☐ Other (specify) ☐ Crisis Residence ☐ Jail/Correctional Facility

4. What is your child's highest education level completed?

(12= GED and High School diploma or self-contained special ed classes)

- a. If enrolled in school, has your child attended school at any time in the past 3 months? ☐ Yes ☐ No ☐ Refused

5. Please answer the following questions based on the past 30 days:

- a. Has your child been arrested? ☐ Yes ☐ No ☐ Refused
b. Did you have enough money to meet your child's needs? ☐ Yes ☐ No ☐ Refused
c. Have you been satisfied with the conditions of your child's living space? ☐ Yes ☐ No ☐ Refused

d. In the past 30 days, has your child felt...

- | | |
|--|---|
| i. Nervous? | ☐ Yes ☐ No ☐ Refused |
| ii. Hopeless? | ☐ Yes ☐ No ☐ Refused |
| iii. Restless or fidgety? | ☐ Yes ☐ No ☐ Refused |
| iv. So depressed that nothing could cheer your child up? | ☐ Yes ☐ No ☐ Refused |
| v. That everything is an effort? | ☐ Yes ☐ No ☐ Refused |
| vi. Worthless? | ☐ Yes ☐ No ☐ Refused |
| vii. Bothered by psychological or emotional problems? | ☐ Yes ☐ No ☐ Refused |

Division of Behavioral Health
Family Mental Health Disorder Outcome Tool

6. Please answer the following questions based on the past 6 months:

- a. Has your child spent time in a facility for:
- i. *Detoxification/Inpatient or Residential Substance Use Disorder Treatment?* ☐ Yes ☐ No ☐ Refused
 - ii. *Mental Health Care?* ☐ Yes ☐ No ☐ Refused
 - iii. *Any illness, injury, or surgery to the human body?* ☐ Yes ☐ No ☐ Refused
- b. Has your child spent time in a correctional facility including jail/prison/detention (because of an arrest, parole, or probation violation)? ☐ Yes ☐ No ☐ Refused

- c. Has your child had suicidal thoughts? ☐ Yes ☐ No ☐ Refused

7. Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion for your child over the <u>past 6 months</u> .	Response Options						
	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable	Refused

Domain: Social Connectedness Questions a-g

- | | | | | | | | |
|--|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. My child is happy with the friendships they have, their friends will listen and understand them when talking. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. My child has people with whom they can do enjoyable things. | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. I feel my child belongs in the community. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. In a crisis, my child would have the support they need from family or friends. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. My child has people that they are comfortable talking with. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. My child has family or friends that are supportive of their recovery. | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. My child generally accomplishes what they set out to do. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Domain: Functioning Questions h-q

- | | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| h. My child does things that are more meaningful to them. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| i. My child can take care of their needs. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| j. My child can handle things when they go wrong. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| k. My child can do things that they want to do. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Division of Behavioral Health
Family Mental Health Disorder Outcome Tool

Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion for your child over the past 6 months.	Response Options						
	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable	Refused
l. My child gets along with family, friends, and other people.	☐	☐	☐	☐	☐	☐	☐
m. My child can deal with crisis.	☐	☐	☐	☐	☐	☐	☐
n. My child does well in social situations.	☐	☐	☐	☐	☐	☐	☐
o. My child does well in school and/or work.	☐	☐	☐	☐	☐	☐	☐
p. My child's symptoms are not bothering them as much.	☐	☐	☐	☐	☐	☐	☐
q. My child's housing situation is a safe place to live.	☐	☐	☐	☐	☐	☐	☐

Division of Behavioral Health
Adult and Youth Mental Health Disorder Outcome Tool

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

Date: _____

Tool Type:

- ☐ Initial
☐ Update
☐ Discharge

- ☐ Adult
☐ Youth

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

- ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. What is your employment status?

- ☐ Employed full time (35+ hours per week) ☐ Employed part time ☐ Homemaker
☐ Student ☐ Retired ☐ Other (specify)
☐ Disabled ☐ Unemployed

3. Which of the following best describes your current residential status?

- ☐ Independent, living in a private residence ☐ Homeless ☐ Dependent, living in a private residence
☐ Residential Care (group home, rehabilitation center, agency-operated care) ☐ Foster Home/ Foster Care ☐ Institutional setting (24/7 care by skilled/specialized staff/doctors)
☐ Other (specify) ☐ Crisis Residence ☐ Jail/Correctional Facility

4. What is your highest education level completed?

(12= GED and High School diploma or self-contained special ed classes)

- a. If enrolled in school, have you attended school at any time in the past 3 months? ☐ Yes ☐ No ☐ Refused

5. Please answer the following questions based on the past 30 days:

- a. Have you been arrested? ☐ Yes ☐ No ☐ Refused
b. Did you have enough money to meet your needs? ☐ Yes ☐ No ☐ Refused
c. Have you been satisfied with the conditions of your living space? ☐ Yes ☐ No ☐ Refused
d. In the past 30 days, have you felt...

- | | |
|---|---|
| i. Nervous? | ☐ Yes ☐ No ☐ Refused |
| ii. Hopeless? | ☐ Yes ☐ No ☐ Refused |
| iii. Restless or fidgety? | ☐ Yes ☐ No ☐ Refused |
| iv. So depressed that nothing could cheer you up? | ☐ Yes ☐ No ☐ Refused |
| v. That everything is an effort? | ☐ Yes ☐ No ☐ Refused |
| vi. Worthless? | ☐ Yes ☐ No ☐ Refused |
| vii. Bothered by psychological or emotional problems? | ☐ Yes ☐ No ☐ Refused |

Division of Behavioral Health
Adult and Youth Mental Health Disorder Outcome Tool

6. Please answer the following questions based on the past 6 months:

a. Have you spent time in a facility for:

- | | |
|--|---|
| i. Detoxification/Inpatient or Residential Substance Use Disorder Treatment? | ☐ Yes ☐ No ☐ Refused |
| ii. Mental Health Care? | ☐ Yes ☐ No ☐ Refused |
| iii. Any illness, injury, or surgery to the human body? | ☐ Yes ☐ No ☐ Refused |

b. Have you spent time in a correctional facility including jail/prison/JDC (because of an arrest, parole, or probation violation)? ☐ Yes ☐ No ☐ Refused

c. Have you had suicidal thoughts? ☐ Yes ☐ No ☐ Refused

7. 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.

Response Options:

Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable	Refused
-------------------	----------	-----------	-------	----------------	----------------	---------

Domain: Social Connectedness Questions a-g

- | | |
|--|---|
| a. I am happy with the friendships I have, who will listen and understand me when talking. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| b. I have people with whom I can do enjoyable things. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| c. I feel I belong in the community. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| d. In a crisis, I would have the support I need from family or friends. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| e. I have people that I am comfortable talking with about my problems. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| f. I have family or friends that are supportive of my recovery. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| g. I generally accomplish what I set out to do. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

Domain: Functioning Questions h-q

- | | |
|--|---|
| h. I do things that are more meaningful to me. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| i. I can take care of my needs. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| j. I can handle things when they go wrong. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| k. I can do things that I want to do. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| l. I get along with family, friends, and other people. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| m. I can deal with crisis. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| n. I do well in social situations. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| o. I do well in school and/or work. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| p. My symptoms are not bothering me as much. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| q. My housing situation is a safe place to live. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |



GAIN Short Screener (GAIN-SS)
Version [GVER]: GAIN-SS ver. 3.0

What is your name? a. _____ b. _____ c. _____
(First name) (M.I.) (Last name)

What is today's date?

The following questions are about common psychological, behavioral, and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

- IDSr 1. **When was the last time** that you had **significant** problems with...
- a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?
 - b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?
 - c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?
 - d. becoming very distressed and upset when something reminded you of the past?
 - e. thinking about ending your life or committing suicide?
 - f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?
- EDScr 2. **When was the last time** that you did the following things **two or more times**?
- a. Lied or conned to get things you wanted or to avoid having to do something
 - b. Had a hard time paying attention at school, work, or home.
 - c. Had a hard time listening to instructions at school, work, or home.
 - d. Had a hard time waiting for your turn.
 - e. Were a bully or threatened other people
 - f. Started physical fights with other people
 - g. Tried to win back your gambling losses by going back another day.
- SDScr 3. **When was the last time** that...
- a. you used alcohol or other drugs weekly or more often?
 - b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?
 - c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?
 - d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?
 - e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?

(Continued)

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.

Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
4	3	2	1	0

CVScr 4. **When was the last time that you...**

- had a disagreement in which you pushed, grabbed, or shoved someone?.....
- took something from a store without paying for it?
- sold, distributed, or helped to make illegal drugs?
- drove a vehicle while under the influence of alcohol or illegal drugs?.....
- purposely damaged or destroyed property that did not belong to you?.....

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (Please describe)

v1. _____

6. What is your gender? (If other, please describe below)

v1. _____

7. How old are you today? Age

- 7a. How many minutes did it take you to complete this survey? Minutes

Staff Use Only	
8. Site ID: _____	Site name v. _____
9. Staff ID: _____	Staff name v. _____
10. Client ID: _____	Comment v. _____
11. Mode: _____	
13. Referral: MH ☐ SA ☐ ANG ☐ Other ☐ 14. Referral codes: _____	
15. Referral comments: v1. _____	

Scoring					
Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDSr	1a – 4e				