

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
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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 SSI.

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 _____

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.

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: _____

Financial Agreement

The typical fees for service are as follows:

Outpatient Intake	\$176
Outpatient Therapy (per hour)	\$171 - \$384
Psychiatric Evaluation	\$286 - \$361
Medication Management	\$187 - \$251

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 1/2% per month.

I have read and understand the above information.

Signature of Client/Parent/Guardian

Date

Witness

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 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

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)

provided with a copy of the Consumer's Rights.

PARENTIAL INFORMATION SHEET
Therapy 8 - 11 year old's

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

INTAKE QUESTIONNAIRE- ADOLESCENT VERSION- AGE 8-11

Name: _____ Sex M F Age: _____ Todays Date: _____

Grade: _____ School: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING EITHER YES OR NO

It is easy for me to make friends at school	YES / NO
I like my teachers	YES / NO
I get along with me parents most of the time	YES / NO
I sometimes wake up at night and have a hard time going back to sleep	YES / NO
I have one best friend with whom I play even outside of school	YES / NO
School work is hard for me	YES / NO
I keep thinking about bad stuff in my head.	YES / NO
I worry almost all of the time.	YES / NO
I think others like me.	YES / NO
I think I am to fat.	YES / NO
I feel safe at school.	YES / NO
My brothers/ sisters and I fight a lot.	YES / NO
Sometimes I wish I were dead.	YES / NO

Please tell us what kinds of things you like to do: _____

PLEASE CIRCLE ALL THE FOLLOWING THAT DISCRIBE HOW YOU USUALLY INTERACT WITH
OTHER PEOPLE

I'M A FOLLOWER	SELF-SACRIFICING	ISOLATE MYSELF	MANIPULATIVE
COOPERATIVE	INDEPENDENT	QUIET JOKER	CONFIDENT ARGUMENTATIVE
EASILY HURT	I'M A LEADER	BRAGGING	SOCIALBLE RESPECTFUL

PLEASE CIRCLE ALL THAT APPLY TO YOUR RELATIONSHIP WITH YOUR PARENTS/ GAURDIANS

WE ARGUE A LOT THEY ARE TOO STRICT WE JOKE AROUND TOGETHER
THEY SAY HURTFUL THINGS TO ME I SNEAK AROUND THEM WE EAT MEALS TOGETHER
WE ALL GO OUR OWN WAY THEIR RULES ARE REASONABLE I RESPECT THEM
I GET PHYSICALLY HURT BY THEM SOMETIMES THEY RESPECT ME THEY YELL A LOT
THEY FIGHT AND ARGUE WITH EACH OTHER THEY SAY I LOVE YOU OR HUG ME

PLEASE CIRCLE YES OR NO FOR ALL THE FOLLOWING SCHOOL EXPERIENCE STATEMENTS

I generally like my teachers	Yes / No
Other's tease me at school	Yes / No
I enjoy socializing with other students at lunch	Yes / No
I skip classes or the whole day of school a couple times a month	Yes / No
I like most my classes	Yes / No
I am tardy many days	Yes / No
I felt mad enough to hurt people at school	Yes / No
I feel respected at school	Yes / No
I have been suspended/ expelled from school in the past	Yes / No
I enjoy extra-curricular activities	Yes / No
School is very stressful for me	Yes / No

**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? _____

Division of Behavioral Health
Family Mental Health Disorder Outcome Tool

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

Date: _____

Tool Type:

- | | |
|------------------------------------|---------------------------------|
| ☐ Initial | ☐ Family |
| ☐ Update | |
| ☐ Discharge | |

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 past 6 months.

Response Options

Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable	Refused
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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.	☐	☐	☐	☐	☐	☐	☐