CLIENT APPLICATION

DATE OF APPLICATION _____

CLIENT DEMOGRAPHIC INFORMATION

Client Name: _____ DOB: _____ Age: _____ SSN#_____

Maiden Name:_____

Current Address: _____

Marital Status: ☐ Single, Never Married ☐ Married ☐ Divorced ☐ Widow

Gender: ☐ Male ☐ Female

Sexual Orientation: ☐ Straight/Heterosexual ☐ Bisexual ☐ Lesbian/Gay ☐ Other_____

Is the client pregnant? ☐ Yes ☐ No If yes, Due Date: _____

Ethnicity/Race

☐ Hispanic/Latino ☐ Not Hispanic/Latino

☐ African American ☐ Caucasian/White ☐ Alaskan Native ☐ Russian

☐ Pacifica Islander ☐ Asian ☐ Declined to specify

INSURANCE INFORMATION

Primary Insurance: _____ Policy ID # _____

Coverage Start Date: _____ Coverage End Date: _____

Policy Holder: ☐ Self ☐ Other

EMPLOYMENT STATUS

☐ Employed ☐ Unemployed, seeking work ☐ Unemployed, not seeking work ☐ Student

☐ Disabled ☐ Homemaker ☐ Other: _____

☐ Veteran *if veteran please list status (active, discharged, or dependent)* _____

_____

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PO Box 876646 Wasilla, AK 99687-6646
7335 E Palmer-Wasilla HWY Palmer, AK 99645
Phone 907-745-6200 FAX 907-745-6211

CONTACT INFORMATION

Parent/Guardian Name:_____ Relationship To Client:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: _____ Email: _____

PERSONAL CONTACTS (scheduling and pick-up/drop-off)

Name:_____ Phone:_____ Relation:_____

Name:_____ Phone:_____ Relation:_____

EMERGENCY CONTACTS

Name:_____ Phone:_____ Relation:_____

Name:_____ Phone:_____ Relation:_____

Initial:____ ***I understand that this correspondence my contain information relating to mental health diagnosis and/or treatment.***

Initial:____ ***I understand and consent to the use of all electronic communication, text messages, and email and that those forms of communication all have potential security risks.***

IF CLIENT IS UNDER OCS FUARDIANSHIP

Social Worker Name:_____

Work Number:_____ Cell:_____ Email:_____

Guardian Ad Litem Name:_____

Work Number:_____ Cell:_____ Email:_____

LIVING ARRANGEMENTS

☐ Adult Foster Care ☐ Child/Adolescent Foster Care ☐ Transitional Housing ☐ Shelter

☐ Private Residence w/Supportive Services Private Residence w/o Supportive Services

☐ Homeless ☐ Other:_____

SCHOOL INFORMATION (*if applicable)*

Name Of Current School:_____ Grade Level:_____

Does Client Have An Individualized Learning Plan? ☐ Yes ☐ No

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FAMILY LIFE

Please list all people who currently live with client:

Name:	Age:	Relation:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are your family supports? _____

What are your family strengths? _____

List any family history of mental illness:_____

Place of Birth: _____

BEHAVIOR

In your own words, what is your primary reason for seeking services:_____

_____

Have mental health behaviors effected the family? ☐ Yes ☐ No

If Yes, explain: _____

Have mental health behaviors effected school/work? ☐ Yes ☐ No

If Yes, explain: _____

PREVIOUS TREATMENT

Is the client currently receiving Mental Health/Substance Use Services? ☐ Yes ☐ No

If Yes, where: _____

Has the client received Mental Health/Substance Use in the past? ☐ Yes ☐ No

If Yes, where: _____ Date: _____

☐ Check if you need additional space to complete.

Medication Assisted Opioid Therapy ☐ Current ☐ Previous

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PRIMARY CARE PHYSICIAN

Physician or Clinic Name:_____ Phone Number:_____

MEDICAL HISTORY

Has the client had any serious medical concerns we should know about? _____

_____

Medical Hospitalizations/Surgeries: _____

_____

Does the client miss school/work due to their physical/mental complaints? ☐ Yes ☐ No

Need for assistive technology? ☐ Yes ☐ No

If Yes, explain: _____

Communicable disease concerns: _____

Prior Psychiatric Diagnosis? ☐ Yes ☐ No

If Yes, Check all that apply:

☐ Depression ☐ Panic/Anxiety Disorder ☐ Bipolar I/II ☐ Personality Disorder ☐ Schizophrenia

☐ Thought Disorder/Paranoid/Delusional ☐ Conduct Disorder ☐ Asperger's ☐ ODD ☐ OCD

☐ ADHD ☐ Other: _____

List all current medications:

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any Drug Allergies? ☐ Yes ☐ No ☐ If Yes, medication: _____

REFERRAL SOURCE

☐ Office Of Children's Services ☐ Teen Challenge ☐ Court Order ☐ Children's Place ☐ Set Free Alaska

☐ Other: _____

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