

**ALASKA FAMILY SERVICES**  
**5851 E. Mayflower Ct.**  
**Wasilla, AK 99654**  
**Ph(907)376-4000 Fax(907)373-1135**

<b>CLIENT PROFILE</b>	Date _____
First Name _____	Maiden Name _____
Middle Name _____	Provider Client ID _____
Last Name _____	Alternate Name(s) _____
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Alternate Name(s) _____
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> Age _____	Home Phone _____ Fax _____
Social Security Number _____	Work Phone _____ Other Phone _____
Driver's License Number _____ State _____	Cell Phone _____
Medicaid Number _____	Email address _____
Home Street Address _____	
City _____ State _____ Zip _____	
Mailing/Billing Address _____	
City _____ State _____ Zip _____	

Race	<input type="checkbox"/> Aleut <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Athabascan (Other than American Indian) <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Haida <input type="checkbox"/> Inupiat <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Alaska Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Tlingit <input type="checkbox"/> Tsimshian <input type="checkbox"/> Yupik <input type="checkbox"/> Other (Specify): _____
Ethnicity	<input type="checkbox"/> Not Spanish/Hispanic/Latino Mexican <input type="checkbox"/> Chicano/Other Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic-specific origin not specified <input type="checkbox"/> Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Spanish/Hispanic Latino

Community of Origin (city, town or village where you currently reside) \_\_\_\_\_

Special Needs	<input type="checkbox"/> None <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Major Diff. In Ambulatory or Nonambulation <input type="checkbox"/> Moderate to Severe Medical Problems <input type="checkbox"/> Organically Based Problem <input type="checkbox"/> Severe Hearing Loss or Deaf <input type="checkbox"/> Traumatic Brain Injury (TBI) <input type="checkbox"/> Visual Impairment or Blind <input type="checkbox"/> Other <input type="checkbox"/> Unknown
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English Fluency	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Moderate <input type="checkbox"/> Poor <input type="checkbox"/> Not at all
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Other (Specify): _____
Interpreter Needed	<input type="checkbox"/> Yes <input type="checkbox"/> No

Education	<input type="checkbox"/> Highest Completed Grade is _____ <input type="checkbox"/> HS Diploma <input type="checkbox"/> BA/BS Degree <input type="checkbox"/> AA Degree <input type="checkbox"/> GED <input type="checkbox"/> Voc Training (Beyond HS) <input type="checkbox"/> Master's
Veteran Status	<input type="checkbox"/> Rsrvs/Nat Guard:Combat <input type="checkbox"/> Never in Military <input type="checkbox"/> Rsrvs/Nat Guard:Noncombat <input type="checkbox"/> Other (Specify): _____
Citizenship	<input type="checkbox"/> United States <input type="checkbox"/> Other (Specify): _____

<b>Collateral Contacts</b>			
1)	First Name _____	Last Name _____	Relation _____
Address _____			
Home Phone _____	Work Phone _____	Cell Phone _____	Other _____
Can we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No      Consent On File? <input type="checkbox"/> Yes <input type="checkbox"/> No			

2) First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Relation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other \_\_\_\_\_

Can we contact? Yes No Consent On File? Yes No

3) First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other \_\_\_\_\_

Can Contact? Yes No Consent On File? Yes No

Who referred you to our agency? (Specify Agency and Name of Person) \_\_\_\_\_

Why are you seeking services at our agency? \_\_\_\_\_

In your own words, what problem(s) would you like our agency to help you with?

Have you ever received services from our agency? Yes No If yes, when and what type of services did you receive?

Are you currently receiving mental health and/or substance abuse treatment services from any other agency? Yes No If yes, which agency and what type of services?

**Medical Status (Admission Profile)**

If female are you pregnant? Yes No Unknown If yes, what is your Due Date? \_\_\_\_\_

Are you an Injection Drug User? Yes No If yes, when was the last time you injected drugs? \_\_\_\_\_

How many times have you been admitted into any program(s) for substance abuse treatment?  How would you rank your overall Health? Excellent Very Good Good Fair Poor Unsure

How many non-treatment substance abuse related hospitalizations have you had in the past 6 months?  Do you have any Mental Health Problems? Yes No If yes, please describe below \_\_\_\_\_

How many times have you been admitted into any program(s) for mental health treatment?  \_\_\_\_\_

How many times have you been hospitalized for mental health treatment?  \_\_\_\_\_

How many months since your last discharge?  \_\_\_\_\_

Do you use tobacco? Yes No If yes, what type do you use? Cigarette Cigars/Pipes Combination Smokeless Tobacco

**Financial Info (Admission Profile)**

Select the description that describes your Employment Status:

<input type="checkbox"/> Disabled	<input type="checkbox"/> Employed Full-Time	<input type="checkbox"/> Employed Part-Time	<input type="checkbox"/> Homemaker	<input type="checkbox"/> In the Armed Forces	<input type="checkbox"/> Not in Labor Force; Other _____	<input type="checkbox"/> Not seeking work	<input type="checkbox"/> Other _____	<input type="checkbox"/> Resident/Inmate	<input type="checkbox"/> Retired	<input type="checkbox"/> Seasonal Employment: In-Season	<input type="checkbox"/> Seasonal Employment: Out of Season	<input type="checkbox"/> Student	<input type="checkbox"/> Unemployed - Not Seeking Work	<input type="checkbox"/> Unemployed - Subsistence Lifestyle	<input type="checkbox"/> Unemployed - Looking for Work	<input type="checkbox"/> Unknown
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If employed, who is your employer? \_\_\_\_\_

Occupation \_\_\_\_\_ Within the last 6 months, how many months have you been employed?

What is your Household Income?  0-999  1,000-4,999  5,000-9,999  10,000-19,999  20,000-29,999  30,000-39,999  40,000-49,999  50,000+

What is your Primary Source of Income? (Please Select One)

<input type="checkbox"/> AK Native Corp Dividends	<input type="checkbox"/> Interest and Other	<input type="checkbox"/> Railroad Retirement	<input type="checkbox"/> Spouse's or Sig. Other's Income
<input type="checkbox"/> Alaska PFD	<input type="checkbox"/> None	<input type="checkbox"/> Retrmnt, Survivor, Disab. Pension	<input type="checkbox"/> Supplemental Security Inc (SSI)
<input type="checkbox"/> Alimony	<input type="checkbox"/> Other _____	<input type="checkbox"/> Self Employment	<input type="checkbox"/> Unemployment Compensation
<input type="checkbox"/> Child Support	<input type="checkbox"/> Parent's Income	<input type="checkbox"/> Social Security	<input type="checkbox"/> Unknown
<input type="checkbox"/> Employment	<input type="checkbox"/> Public Assist/Welfare Pay	<input type="checkbox"/> Social Security Disability (SSDI)	

How do you plan to pay for treatment services?

<input type="checkbox"/> AK Native Health Care	<input type="checkbox"/> HMO	<input type="checkbox"/> No Charge	<input type="checkbox"/> Other Public
<input type="checkbox"/> Blue Cross/Blue Shield	<input type="checkbox"/> Indian Health Services	<input type="checkbox"/> Other Government Grant	
<input type="checkbox"/> CIGNA	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other Native Health Grant	
<input type="checkbox"/> Self Pay	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other Private	

What type of Insurance do you have?

<input type="checkbox"/> Auto Insurance Policy	<input type="checkbox"/> Litigation	<input type="checkbox"/> Medicare Primary	<input type="checkbox"/> Personal Payment (Cash - No Insurance)
<input type="checkbox"/> Commercial	<input type="checkbox"/> Long Term Policy	<input type="checkbox"/> Medigap Part B	<input type="checkbox"/> Supplemental Policy
<input type="checkbox"/> Group Policy	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other _____	<input type="checkbox"/> VA Insurance
<input type="checkbox"/> Health Main. Org. (HMO)	<input type="checkbox"/> Medicare Conditionally Primary	<input type="checkbox"/> Other Private Insurance	
<input type="checkbox"/> Individual Policy	<input type="checkbox"/> Medicare Part B	<input type="checkbox"/> Other Public Insurance	

Do you have any of the following as other income sources: (Please Select All that Apply)

<input type="checkbox"/> AK Native Corp Dividends	<input type="checkbox"/> Interest and Other	<input type="checkbox"/> Railroad Retirement	<input type="checkbox"/> Spouse's or Sig. Other's Income
<input type="checkbox"/> Alaska PFD	<input type="checkbox"/> None	<input type="checkbox"/> Retrmnt, Survivor, Disab. Pension	<input type="checkbox"/> Supplemental Security Inc (SSI)
<input type="checkbox"/> Alimony	<input type="checkbox"/> Other	<input type="checkbox"/> Self Employment	<input type="checkbox"/> Unemployment Compensation
<input type="checkbox"/> Child Support	<input type="checkbox"/> Parent's Income	<input type="checkbox"/> Social Security	<input type="checkbox"/> Unknown
<input type="checkbox"/> Employment	<input type="checkbox"/> Public Assist/Welfare pay	<input type="checkbox"/> Social Security Disability (SSDI)	

**Household Composition**

Select description that best describes your Household Composition:

<input type="checkbox"/> Live Alone	<input type="checkbox"/> w/ Non-Relatives	<input type="checkbox"/> Other	<b>What is your Marital Status?</b>	<input type="checkbox"/> Cohabiting	<input type="checkbox"/> Never Married-Single	<input type="checkbox"/> Widowed
<input type="checkbox"/> w/ Adolescents	<input type="checkbox"/> w/ Relatives		<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated		
<input type="checkbox"/> w/ Children	<input type="checkbox"/> w/ Significant Other		<input type="checkbox"/> Married	<input type="checkbox"/> Unknown		

Select description that best describes your Living Arrangement:

<input type="checkbox"/> Adult Foster Care	<input type="checkbox"/> Hospital for Psychiatric Purposes	<input type="checkbox"/> Private Residence w/o supports
<input type="checkbox"/> Alone	<input type="checkbox"/> In-Household w/ non-related persons	<input type="checkbox"/> Residential Treatment
<input type="checkbox"/> Assisted Living Home	<input type="checkbox"/> In-Household w/ relatives	<input type="checkbox"/> Shelter
<input type="checkbox"/> Child/Adolescent Foster Care	<input type="checkbox"/> Jail/Correctional Facility	<input type="checkbox"/> Substance Abuse Halfway House
<input type="checkbox"/> Correctional Halfway House	<input type="checkbox"/> Juvenile Detention	<input type="checkbox"/> Transitional Housing
<input type="checkbox"/> Group Home	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Unknown
<input type="checkbox"/> Homeless	<input type="checkbox"/> Other	
<input type="checkbox"/> Hospital for Non-Psychiatric Purposes	<input type="checkbox"/> Private residence w/ supports	

How many people live with you?  How many children live with you in a residential setting?  How many children are in your household?  Of the children who live with in a residential setting, how many are currently receiving services?

Do any of the following live with you? (Select All that Apply)

<input type="checkbox"/> Aunt(s)	<input type="checkbox"/> Guardian	<input type="checkbox"/> Son(s)	<input type="checkbox"/> Significant Others
<input type="checkbox"/> Brother(s)	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Step Father	<input type="checkbox"/> Spouse
<input type="checkbox"/> Daughter(s)	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Sister(s)	<input type="checkbox"/> Uncle(s)
<input type="checkbox"/> Father	<input type="checkbox"/> Other Relatives	<input type="checkbox"/> Stepmother	<input type="checkbox"/> Unrelated

If you have resided in a Controlled Environment in last 30 days, please select the description that best fits that environment.

<input type="checkbox"/> Alcohol/Drug Tx	<input type="checkbox"/> Jail	<input type="checkbox"/> Medical Tx	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Psychiatric Tx
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**Legal History**

Please select the description that best describes your Legal Status:

<input type="checkbox"/> 180 Day Commitment	<input type="checkbox"/> Court order for observation and evaluation	<input type="checkbox"/> Deferred Sentence	<input type="checkbox"/> Ofc. of Children's Services custody
<input type="checkbox"/> 30 Day Commitment	<input type="checkbox"/> Court ordered for alcohol treatment	<input type="checkbox"/> Emergency commitment	<input type="checkbox"/> Probation/Parole
<input type="checkbox"/> 90 Day Commitment	<input type="checkbox"/> Court ordered juveniles (INT); DJJ custody	<input type="checkbox"/> Furlough/Rehabilitation Leave	<input type="checkbox"/> Protective Custody
<input type="checkbox"/> Case Pending	<input type="checkbox"/> Court ordered juveniles (INT); parents retain custody	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Title 12-Not guilty by reason of insanity (NGRI, (GBMI)
<input type="checkbox"/> Community Sentencing	<input type="checkbox"/> Deferred Prosecution	<input type="checkbox"/> None/No Involvement	<input type="checkbox"/> Unknown

Have you ever been arrested?  Yes  No If yes, how many times have you been arrested in your life?  How many of those arrests took place in the last 12 months?