Alaska Family Services

Phone (907) 376-4000 * FAX (907) 373-1135

CONSENT FOR DISCLOSURE OF INFORMATION

I, ____________________________DOB:___________, request/authorize **Alaska Family Services BHTC** to

______ Disclose information to: and/or _____ Obtain information from:

(nature and amount of information to be disclosed; as limited as possible)

Name: (Self) ____

Address: ____

Phone: ____

Initial all that apply.

________ UA Results
________ Assessment/Interpretive Summary
________ Treatment Plan/Case Reviews
________ Attendance
________ Discharge Summary
________ Leave message for client to contact agency
________ Other: ______________________
____

For the purpose(s) of:

________ Further Treatment
________ Legal Request
________ Coordination of Care
________ Personal
________ Other ______________________
____

Disclosure is to be: **verbally, in writing and/or by facsimile (fax).**

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: _____ 90 days after discharge, or _____other terms:____ (specification of the date, event or conditions upon which this consent expires) IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE ON ___/___/___.

I understand that generally Alaska Family Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may denied treatment if I do not sign a consent form.

By my signature below I indicate that I have read this document or have had it read to me, that I fully understand its meaning, that I consent to its terms knowingly and voluntarily, that I have not been under any undue duress or influence nor under the influence of alcohol or drugs in making this agreement.

Signature:____ Date:___/___/___
Client

Signature:____ Date:___/___/___
Parent, guardian, or person authorized to sign for client

Signature:____Date:___/___/___
Witness

This notice accompanies a discloser of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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

CLIENT PROFILE

Date ______

First Name ______ Maiden Name ______

Middle Name ______ Provider Client ID ______

Last Name ______ Alternate Name(s) ______

Gender ☐Female ☐Male Alternate Name(s) ______

Date of Birth ☐☐/☐☐/☐☐☐☐ 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	☐Aleut ☐Caucasian ☐Pacific Islander	☐American Indian ☐Haida ☐Tlingit	☐Asian ☐Inupiat ☐Tsimshian	☐Athabascan ☐Native Hawaiian ☐Yupik	☐ Black/African American ☐Other Alaska Native ☐Other (Specify):______
Ethnicity	☐Not Spanish/Hispanic/Latino Mexican ☐Mexican American	☐Chicano/Other Hispanic ☐Puerto Rican	☐Cuban ☐Spanish/Hispanic Latino		☐Hispanic-specific origin not specified

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

Special Needs	☐None ☐Moderate to Severe Medical Problems ☐Traumatic Brain Injury (TBI) ☐Unknown	☐Developmentally Disabled ☐Organically Based Problem ☐Visual Impairment or Blind	☐Major Diff. In Ambulatory or Nonambulation ☐Severe Hearing Loss or Deaf ☐Other

English Fluency	☐Excellent ☐Good ☐Moderate ☐Poor ☐Not at all
Primary Language	☐English ☐Other (Specify)______
Interpreter Needed	☐Yes ☐No

Education	☐Highest Completed Grade is ______ ☐HS Diploma ☐BA/BS Degree ☐AA Degree ☐GED ☐Voc Training (Beyond HS) ☐Master's
Veteran Status	☐Rsrvs/Nat Guard:Combat ☐Rsrvs/Nat Guard:Noncombat ☐Never in Military ☐Other (Specify): ______
Citizenship	☐United States ☐Other (Specify):______

Collateral Contacts

1) First Name ______ Last Name ______ Relation ______

Address ______

Home Phone ______ Work Phone ______ Cell Phone ______ Other ______

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

First Name ______ Last Name ______ Relation ______

______ ______ ______

______ ______ ______

Address ______

Home Phone ______ Work Phone ______ Cell Phone ______ Other ______

Can we 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

Alcohol and Drug Use History

Drug	Age at 1st use:	Age at regular use:	Age at heaviest use:	Heaviest use frequency and amounts:	Past 12 months frequency and amounts:	# of days used in last 30 days:	Date last used	Method of use (oral, smoked, injected, snorted):
Alcohol								
Amphetamine (Adderall, Dexedrine, Concerta, Ritalin, diet drugs)								
Caffeine								
Cannabis (Marijuana, hashish)								
Cocaine/Crack								
Hallucinogens (MDMA/ecstasy, ketamine, LSD, mushrooms)								
Inhalants ("whippets", gasoline, glue, paint, Dust-Off, hair spray, nitrous oxide)								
Methamphetamine ("crank"; "crystal"; "ice")								
Nicotine								
Opioids (heroin, methadone, morphine, opium, oxycodone, hydrocodone, codeine)								

Drug	Age at 1st use:	Age at regular use:	Age at heaviest use:	Heaviest use frequency and amounts:	Past 12 months frequency and amounts	# of days used in last 30 days:	Date last used	Method of use (oral, smoked, injected, snorted):
Phencyclidine (PCP, Angel Dust, etc.)								
Sedatives or Anxiolytic (Valium, Xanax, Klonopin, Ativan, Rohypnol, GHB)								
Synthetic Drugs (K2/Spice, MDMA/Bath salts)								
Over the counter drugs (DXM, "skittles", cough medications, No-Doz, sleep aids, Benedryl, dramamine)								
Prescription Drugs (any drugs you have been prescribed)								
Other Drugs (ex. Steroids, Salvia)								

IV Use? Yes No

Do you believe alcohol and/or drugs cause problems in your life? Yes No

Did either of your biological parents have a problem with alcohol or drugs?
Explain:

Client treatment history (Where? When? For how long?

CLIENT ADMISSION FORM

Financial/Household Information

Employment Status: **Check One**	Occupation (O-Net): **Check One**	Insurance Type: **Check One**
❒ Disabled ❒ Employed Full Time ❒ Employed Part Time ❒ Homemaker ❒ Armed Forces Medicaid ❒ Not in Labor Force/Other ❒ Not Seeking Work ❒ Other ❒ Resident/Inmate ❒ Retired ❒ Seasonal Employee/in season ❒ Seasonal Employee/out season ❒ Student ❒ Unemployed/Not seeking work ❒ Unemployed/Subsistence ❒ Unemployed/Looking for work	❒ Accommodation & Food Services ❒ Administrative & support Services ❒ Agriculture, Forestry, Fishing, & Hunting ❒ Arts, Entertainment, & Recreation ❒ Construction ❒ Educational Services ❒ Finance & Insurance ❒ Government ❒ Health Care & Social Assistance ❒ Information ❒ Management of Companies & Enterprises ❒ Manufacturing ❒ Mining, Quarrying, Oil & Gas Extraction ❒ Other Services (Except Public Admin.) ❒ Professional, Scientific, & Technical Svcs. ❒ Real Estate & Rental & Leasing ❒ Retail Trade ❒ Self-Employed ❒ Transportation & Warehousing ❒ Utilities ❒ Wholesale Trade ❒ None ❒ Not Applicable	❒ Auto Insurance Policy ❒ Indian Health Service ❒ None ❒ Commercial ❒ Medicare Conditionally Primary ❒ Group Policy ❒ Health Maint. Org. (HMC) ❒ Individual Policy ❒ Long Term Policy ❒ Litigation ❒ Medicare Part B ❒ Medicaid ❒ Medicare Primary ❒ Other Public ❒ Other Private ❒ Other ❒ Personal payment (cash- no ins) ❒ Supplemental Policy ❒ Private Insurance ❒ VA insurance
Primary Income Source: **Check one** ❒ None ❒ Tribal Assistance Programs ❒ Alaska Native Corp Dividends ❒ Alimony ❒ Alaska PFD ❒ Child Support ❒ Employment ❒ Interest & Other ❒ Other ❒ Public Assistance/Welfare Pay ❒ Parent's Income ❒ Spouse/Significant Other Income ❒ Retirement/Surv/Disability Pension ❒ Social Security Disability (SSDI) ❒ SSI ❒ SSI/SSDI Never ❒ SSI/SSDI Previous ❒ Unemployment Compensation	Annual Household Income: *Approximate or exact numeric amount and include Alaska PFD's if applicable* ________________________________	Expected Payment Source: **Check One** ❒ Aetna ❒ AK Native Health Care ❒ Blue Cross/Blue Shield ❒ CIGNA ❒ Client Self Pay ❒ HMO ❒ Indian Health Services ❒ Medicaid ❒ Medicare ❒ No Charge ❒ Other Government Grant ❒ Other Native Health Care ❒ Other Private ❒ Other Public ❒ Sliding Scale; client partial payment ❒ Sliding Scale, No Charge

Household Composition: **Check One**	Living Arrangement: **Check One**
❒ Client Lives alone ❒ Lives with Adolescents ❒ Lives with Children ❒ Lives with Non-relatives ❒ Lives with Relatives ❒ Lives with Significant Other(s) ❒ Significant Other & Children	❒ Assisted Living Facility ❒ Correction/Detention Facility ❒ Crisis Residence ❒ Foster Care ❒ Group Home ❒ Halfway House ❒ Homeless ❒ Hospital for Non-psychiatric purposes ❒ Hospital for psychiatric purposes ❒ Nursing home ❒ Private Residence w/out supportive services ❒ Private residence w/supportive services ❒ Residential Treatment ❒ Shelter ❒ Therapeutic Foster Care ❒ Transitional Housing
Marital Status: **Check one** ❒ Never Married-single ❒ Married ❒ Cohabitating ❒ Separated ❒ Divorced ❒ Widowed	Living in Home: **Answer all** Number of people living with client: #____ Number of children in household: #____ Number of children in Residential Setting: #____ Number of children in Residential Setting receiving services: #____

Number of Days Abstinent (no use of alcohol, Marijuana, or illegal drugs) in Last 30 Days: _____

Do You Currently Use Tobacco: **Check one**

____ Cigarettes ___Cigars/Pipes ___Combo ___Smokeless Tobacco ___No

Number of Arrests in **past 30** days: #________

ALASKA FAMILY SERVICES
BEHAVIORAL HEALTH TREATMENT CENTER
Telephone: (907) 376-4000*FAX: (907) 373-1135

Family Questionnaire

1. By whom were you raised? ____

2. Do you have any siblings? If so what are their ages and gender? ____________________

   ____

3. As a child how would you describe your relationship with your parents?
   a. caring b. strained c. supportive d. honest e. abusive f. critical g. happy h. loving i. conflicted
   j. nonexistent k. other ____

4. As a child how would you describe your relationship with your siblings?
   a. caring b. strained c. supportive d. honest e. abusive f. critical g. happy h. loving i. conflicted
   j. other ____

5. Currently how would you describe your relationship with your parents?
   a. distant b. caring c. strained d. supportive e. conflicted f. loving g. happy h. nonexistent
   i. other ____

6. Currently how would you describe your relationship with your siblings?
   a. caring b. strained c. supportive d. honest e. distant f. critical g. conflicted
   h. other ____

7. Are you married or do you have a significant other? _____ How long have you had this relationship? _______
   How did you meet? ______________________________
   If you are separated or divorced describe your past relationship. ____________________

8. How would you describe your child's relationship with their mother / father?
   a. caring b. strained c. supportive d. distant e. conflicted f. happy g. nonexistent
   h. other ____

9. How would you describe your current relationship?
   a. caring b. strained c. supportive d. honest e. abusive f. critical g. happy h. loving i. conflicted
   j. other ____

10. Children: Please identify age, gender and describe your relationship with your children using *two words* such as happy, distant, caring, critical, honest, abusive or loving

	Age	Gender	Description of Relationship
1			
2			
3			
4			
5			
6			

11. Things in our family are unpredictable and tend to become chaotic. True False

12. I have often been called into school to discuss my child's behavior. True False

13. I would like to improve my family relationships. True False

Alaska Family Service

BEHAVIORAL HEALTH TREATMENT CENTER

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Client Orientation Checklist

Client Initials

_____ 1. Information about Alaska Family Services:

- Reviewed Assessment and provided any corrections needed.
- Received, heard and/or read the Adult Client Handbook.
- Agency Hours of Operation: *Monday through Friday, 8:00 AM to 5:30 PM*
- After Hours Services Access: *Telephone 376-4000, leave your name and telephone number with the answering service, the on-call counselor will telephone you.*

_____ 2. Policies regarding:

- **Smoking:** ***OUTSIDE IN THE BACK OF THE BUILDING IN THE LEFT-HAND CORDER; DO NOT LIGHT UP UNTIL YOU ARE AT THE SMOKING AREA. DO NOT LEAVE YOUR BUTTS ON THE GROUND. NEVER SMOKE IN FRONT OF THE BUILDING.***
- ***Perfume and/or Cologne: DO NOT WEAR ANY PERFUME OR COLOGNE TO GROUPS AND/OR INDIVIDUAL SESSIONS.*** *Many people are allergic to many of them, and can become very ill.*

_____ 3. Client contribution to Quality of Care:

- Client Satisfaction Survey: *While attending treatment, Clients will annually complete a survey.*
- Suggestion box: *There is a suggestion box at the front desk for Client use.*
- Group evaluations: *Evaluation of groups is incorporated into the group progress note completed at the end of the group session.*

_____ 4. Program Assignment:

- Levels of Care: *Intensive Outpatient or Outpatient with progressive levels of decreasing intensity as your success in the recovery process continues.*
- Counselor assignment: *You will be assigned a primary counselor.*
- Group meeting times: *Women's Program: 9:30 AM to 12:30 PM*
Community Services: 6:00 PM to 9:00 PM
- Individual Counseling Sessions: *Scheduled at the front desk*
- Transition criteria and procedures: *Based upon your individual progress toward achieving your individual goals as described in your individual treatment plan.*

***A tour of the building including fire/emergency evacuation exits, fire/emergency assembly location, restrooms, group rooms, suggestion box and counselor offices will be given the day you start treatment. You will receive a copy of the group rules for the appropriate program when you start treatment.

I certify that I have received the Adult Client Handbook, and will follow the rules and regulations; if I have any questions about my rights I can discuss it with my counselor

_________________________________ _______________

Client Signature Date

_________________________________ _______________

Staff Signature Date

ALASKA FAMILY SERVICES
Behavioral Health Treatment Center
Telephone: (907) 376-4000*FAX: (907) 373-1135

CLIENT MEDICAL RELEASE/ EMERGENCY INFORMATION FORM

For Your Safety, the following information will be kept in a secure area, accessible only to staff members, while you are attending group.

All information must be current in case of emergency. Please complete the following:

I, ____, hereby give my consent to be given emergency medical treatment in the event of an accident, injury or illness.

I hereby release the Alaska Family Services and its representatives from any liability rising from an emergency situation in which it is deemed necessary to pursue medical treatment.

In case of an emergency, Alaska Family Services may contact:

1. ______________________________ ______________________________
Name/Relationship Phone #

2. ______________________________ ______________________________
Name/Relationship Phone #

Drug Allergies: ____

Medications: ____

Other medical conditions: ____

____

Insurance Information or Medicaid number: ______________________________

By signing below I authorize disclosure of the above information to appropriate emergency personnel

____
Signature/date

ALASKA FAMILY SERVICES

BEHAVIORAL HEALTH TREATMENT CENTER

Phone (907) 376-4000 * FAX: (907) 373-1135

CLIENT NOTICE

This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information
Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Alaska Family Services (AFS) may not say to a person outside AFS that you attend the program, nor may AFS disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

Alaska Family Services must obtain your written consent before it can disclose information about you for payment purposes. For example, AFS must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before AFS can share information for treatment purposes or for health care operations. However, federal law permits AFS to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/ business associate;
2. For research, audit or evaluations;
3. To report a crime committed on AFS' premises or against AFS personnel;
4. To medical personnel in a medical emergency;
5. As allowed by an authorizing court order.
6. Physical or sexual abuse or neglect committed against a child or elderly person
7. Suicidal or homicidal threats or attempts
8. Internal Communications

For example, AFS can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

Before AFS can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

YOUR RIGHTS
Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. AFS is not required to agree to any restrictions you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. AFS will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by AFS, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in AFS' records, and to request and receive an accounting of disclosures of your health

related information made by AFS during the six years prior to your request. You also have the right to receive a paper copy of this notice.

AFS may deny a client request for amendment if it determines that the information or record:

- **Was not created by an AFS employee**
- **Is not part of a designated record set**
- **Is accurate and complete**

A client, whose request for amendment is denied, may pursue the next appropriate level of the client grievance procedure.

AFS' Duties
AFS is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. AFS is required by law to abide by the terms of this notice. AFS reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Any revisions to this policy will be distributed to you at your next scheduled session or appointment.

Complaints and Reporting Violations
You may complain to AFS and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You may file a complaint if you believe your privacy rights have been violated by completing a complaint form (available at the front desk) and following the steps of the Grievance Procedures. You will not be subject to retaliation for filing such a complaint.

A violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Contact
For further information, contact ***AFS by telephoning 376-4000.***

Effective Date
8/03

Acknowledgement
I hereby acknowledge that I received a copy of this notice.

Dated: ____________________ Patient Signature:______________________________________

Alaska Family Services
BEHAVIORAL HEALTH TREATMENT CENTER
Phone: 907-376-4000 Fax: 907-373-1135

CONSUMER GRIEVANCE PROCEDURE

PROCEDURE

GENERAL

1. Consumers have a right to file a grievance without intimidation and there will be no retaliation against a consumer that files a grievance.
2. Consumers will be informed of the Alaska Family Services "Consumer Grievance Procedure" upon entry to services. A copy of this form will be signed and included in the consumer's clinical record.
3. Consumers may designate a representative or an advocate to assist with all steps of the grievance process.
4. Consumers may request assistance from an Alaska Family Services office administrative staff member in filing a grievance.
5. Grievances may be submitted in writing (attachment), orally/in person, through email or over the telephone. Grievances submitted orally will be documented (attachment) in writing by the staff member receiving the report from the consumer.
6. Grievances that are not resolved by Alaska Family Services within 30 days will be referred to the Division of Behavioral Health within five (5) working days.
7. Grievances involving abuse, neglect or unnecessary seclusion or restraint will immediately be elevated to Level Four: Board of Directors.
8. All Federal, State, and local laws regarding confidentiality will be followed. Appropriate releases of information (ROI) forms will be obtained as necessary for investigation and retained in the consumer's clinical record.
9. Documentation of the grievance process, including decisions will be included in the consumer's clinical record and Alaska Family Services' administrative files.
10. Decisions made to resolve the grievance will be carried out and documented by the appropriate Alaska Family Services staff.

LEVEL ONE: INFORMAL

A consumer should attempt to resolve her/his complaint on an informal basis with the counselor or staff person before entering the formal grievance process.

LEVEL TWO: FORMAL

If the grievance is not resolved at Level One, the consumer shall submit the grievance for review by the Alaska Family Services Clinical Director. The grievance shall outline the nature of the grievance, the circumstances from which it arose, and the remedy or correction desired. Within five (5) working days after the grievance is received, the Clinical Director shall render her/his decision in writing with copies to the consumer and the Chief Executive Officer. If a decision cannot be made within five (5) working days the Clinical Director will notify the consumer and Chief Executive Officer explaining why and identifying when the grievance process will be completed at this level.

LEVEL THREE: CHIEF EXECUTIVE OFFICER

If the grievance is not resolved at Level Two, the consumer shall submit the grievance to the Chief Executive Officer. The Chief Executive Officer will render her/his decision within five (5) working days of receiving the grievance.

LEVEL FOUR: BOARD OF DIRECTORS (GOVERNING BOARD)

If the grievance is not resolved at Level Three, the consumer shall submit the grievance to the Board of Directors within five (5) working days after receipt of a response at Level Three. The Board, or its Executive committee shall meet with all parties involved, at the next regularly scheduled Board meeting. The Board shall make their decision known in writing within five (5) working days following the meeting.

LEVEL FIVE: DIVISION OF BEHAVIORAL HEALTH

If the grievance is not resolved at Level Four, the consumer shall submit the grievance to the State of Alaska, Division of Behavioral Health within five (5) working days after receipt of a response at Level Four. The Division shall designate a State employee to investigate the complaint and provide the consumer a decision in writing. The decision of the Division of Behavioral Health is final

I have read and understand the Consumer Grievance Procedures.

____

Printed name Consumer Signature Date

________________________________ ______________________

Agency Representative Signature Date

Alaska Family Services
BEHAVIORAL HEALTH TREATMENT CENTER
Phone: 907-376-4000 Fax: 907-373-1135

HEALTH REVIEW AND RISK ASSESSMENTS

Health History:

Yes	No	
☐	☐	Any major illness or injury in the last 5 years
☐	☐	Any head or brain injuries, disorders or illnesses
☐	☐	Any seizures or epilepsy
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart disease or heart attack; other cardiovascular condition
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
☐	☐	High blood pressure
☐	☐	Muscular disease
☐	☐	Shortness of breath
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis
☐	☐	Kidney disease, dialysis
☐	☐	Liver disease
☐	☐	Digestive problems
☐	☐	Diabetes or elevated blood sugar controlled by:
		☐ diet
		☐ pills
		☐ insulin
☐	☐	Nervous or psychiatric disorders, e.g., severe depression
☐	☐	Loss of, or altered consciousness
☐	☐	Fainting, dizziness
☐	☐	Problems with eating or sleeping
☐	☐	Dental problems
☐	☐	Stroke or paralysis
☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Spinal injury or disease
☐	☐	Chronic low back pain
☐	☐	Regular, frequent alcohol use
☐	☐	Narcotic or habit forming drug use
☐	☐	Allergies
☐	☐	Skin Problems
☐	☐	Do you have a personal physician or health clinic?

Date of last Physical Exam: ______________________________

1. Females:

Number of sexual partners in the last year (circle): 0-1 2-5 5-10 10+

Yes	No	
☐	☐	Use protection when sexually active.
☐	☐	Past or present sexual relations with someone who has HIV, AIDS, or Hepatitis.
☐	☐	Sexual relations while under the influence of drugs or alcohol.
☐	☐	Traded sex for drugs or alcohol.
☐	☐	Had sex against your will.
☐	☐	Pregnant?
☐	☐	Gynecological Issues ________________________________
☐	☐	Sexually transmitted diseases:

- ☐ Herpes
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Genital Warts
- ☐ Other:_______________________________________

2. Males:

Number of sexual partners in the last year (circle): 0-1 2-5 5-10 10+

Date of last prostrate exam: _________________________

Yes	No	
☐	☐	Use protection when sexually active
☐	☐	Past or present sexual relations with someone who has HIV, AIDS, or Hepatitis.
☐	☐	Sexual relations while under the influence of drugs or alcohol.
☐	☐	Traded sex for drugs or alcohol.
☐	☐	Had sex against your will.
☐	☐	Sexually transmitted diseases:

- ☐ Herpes
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Genital Warts
- ☐ Other: _____________________________________

3. Tuberculosis Risk Assessment:

Yes	No	
☐	☐	Prolonged, productive cough that produces discharge
☐	☐	Chest pain
☐	☐	Coughing up blood
☐	☐	Fever and chills
☐	☐	Night sweats
☐	☐	Weight loss
☐	☐	Feeling "run down" or easily tired
☐	☐	Chronic pain
☐	☐	Blood in urine
☐	☐	Exposed to a person with tuberculosis or TB
☐	☐	Immigrated or a refugee within the last 10 years
☐	☐	Moved to US from Mexico, Vietnam, China, India, Haiti, Korea, Philippines, or Polynesia
		Date of last Tuberculosis test: ______________________________
☐	☐	Test was positive
☐	☐	Completed treatment for Tuberculosis

Medical problems of biological parents you may have inherited, such as a tendency toward heart disease, diabetes, or cancer.

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List all Medications:

Name:	**Dosage:**	**Frequency:**

List all Allergies:

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