Key Point
HEALTH SERVICES INC.
OUTPATIENT MENTAL HEALTH PROGRAMS

Client Name: _____ **Client DOB:** _____

CHILD/ADOLESCENT HEATLH HISTORY - MEDICAL

Please explain any selected response(s) on the lines following the selection.

Eyes, Ears, Nose, Throat

☐ None Reported ☐ Glaucoma ☐ Ear/Hearing Problems
☐ Eye/Vision Problems ☐ Throat Problems ☐ Other
☐ Nose Problems/Nosebleeds

_____
_____

Musculoskeletal

☐ None Reported ☐ Bone/Joint Difficulty ☐ Back Pain/Injuries
☐ Arthritis ☐ Other
☐ Gout

_____
_____

Blood/Lymphatic System

☐ None Reported ☐ Bleed Easily ☐ Bruise Easily
☐ Anemia (Low RBC Count)
☐ Other

_____
_____

Circulatory/Cardiac Systems

☐ None Reported ☐ High Blood Pressure ☐ Irregular Heart Beat
☐ Coronary Artery Disease ☐ Heart Murmur ☐ Chest Pain
☐ Angina ☐ Abnormal EKG ☐ Heart Attack
☐ Rheumatic Fever
☐ Other

_____
_____

Endocrine System

☐ None Reported ☐ Thyroid Disease ☐ Excessive Thirst
☐ Diabetes ☐ Weight Gain ☐ Weight Loss
☐ Excessive Urination ☐ Menopause Problems ☐ Erectile Dysfunction
☐ Menopause
☐ Other

_____
_____

Gastrointestinal System

- ☐ None Reported
- ☐ Difficulty Swallowing
- ☐ Diverticulitis
- ☐ Pancreatitis
- ☐ Hepatitis A
- ☐ Hemorrhoids/Rectal Disease
- ☐ Vomiting
- ☐ Diverticulosis
- ☐ Liver
- ☐ Ulcer
- ☐ Hepatitis B
- ☐ Reflux
- ☐ Diarrhea
- ☐ Stomach Pain
- ☐ Jaundice
- ☐ Constipation
- ☐ Hepatitis C
- ☐ Nausea
- ☐ Other

Genital/Urinary System

- ☐ None Reported
- ☐ Urinary Tract Problems
- ☐ Sexual Difficulties
- ☐ Prostate
- ☐ Sexual Transmitted Disease
- ☐ Infections
- ☐ Other

Nervous System

- ☐ None Reported
- ☐ Seizures/Epilepsy
- ☐ Loss of Coordination
- ☐ Head Injury
- ☐ Black-Outs
- ☐ Headaches
- ☐ Speech Problems
- ☐ Spinal Cord Injury
- ☐ Dizziness
- ☐ Tremors
- ☐ Loss of Feeling in Hand/Foot
- ☐ Sleep Problems
- ☐ Other

Respiratory System

- ☐ None Reported
- ☐ Difficulty Breathing
- ☐ Pneumonia
- ☐ Other
- ☐ Frequent Coughing
- ☐ Asthma
- ☐ Tuberculosis/Results
- ☐ Bronchitis

Integumentary System

- ☐ None Reported
- ☐ Boils
- ☐ Psoriasis
- ☐ Other
- ☐ Itching
- ☐ Rashes
- ☐ Acne
- ☐ Eczema

Additional Questions

Have you ever had any surgeries? ☐ Yes ☐ No

Have you had cancer? ☐ Yes ☐ No

Any abnormal lab tests/results? ☐ Yes ☐ No

Have you ever had a head injury? ☐ Yes ☐ No
If yes, did you lose consciousness/have a concussion? ☐ Yes ☐ No

=For Females Only:
*Any problems with menstruation? ☐ Yes ☐ No
*Do you plan to become pregnant? ☐ Yes ☐ No
*Do you use birth control? ☐ Yes ☐ No
*Any history of pregnancy, miscarriage or terminations? ☐ Yes ☐ No

CHILD/ADOLESCENT HEALTH HISTORY - FAMILY

If yes, please explain on the lines following selection (family member, health/psychiatric problem)

Has anyone in your family had health problems? ☐ Yes ☐ No

Has anyone in your family had a psychiatric problem? ☐ Yes ☐ No

Has anyone in your family had substance-abuse problems? ☐ Yes ☐ No

CHILD/ADOLESCENT HEALTH HISTORY - PAIN

If yes to either, please explain (on a scale of 1 to 10, 1=lowest, 10=highest, what is your score?)

Are you experiencing any pain right now? ☐ Yes ☐ No

Do you experience any chronic untreated pain? ☐ Yes ☐ No

CHILD/ADOLESCENT HEALTH HISTORY - DEVELOPMENTAL HISTORY

Birth Father's Information: ☐ Unknown
First Name: _____ Last Name: _____ Age at Birth: ____

Birth Mother's Information: ☐ Unknown
First Name: _____ Last Name: _____ Age at Birth: ____

Biological/Birth Parent's Marital Status (at birth and current): ☐ Unknown

_____

_____

Birth Certificate Information (parents identified on birth certificate): ☐ Unknown

_____

_____

Location of Birth (name of center/facility, home-birth): ☐ Unknown

_____

Place of Birth (city, state, province, county): ☐ Unknown

_____

Pregnancy

Was this a planned pregnancy? ☐ Yes ☐ No ☐ Uncertain
Was this a wanted pregnancy? ☐ Yes ☐ No ☐ Uncertain
Was prenatal medical care provided? ☐ Yes ☐ No ☐ Uncertain
Were there health problems/illness during pregnancy? ☐ Yes ☐ No ☐ Uncertain
Were there medical operations/procedures during pregnancy? ☐ Yes ☐ No ☐ Uncertain
Were physical injuries/trauma sustained during pregnancy? ☐ Yes ☐ No ☐ Uncertain
Were there other complications/problems during pregnancy? ☐ Yes ☐ No ☐ Uncertain

Prenatal Exposure (check all that apply)

☐ None Reported
☐ Alcohol
☐ Caffeine
☐ Illicit Drugs
☐ Lead/Mercury
☐ Medications (over-the-counter)
☐ Medications (prescription)
☐ Nicotine
☐ Poisons
☐ Toxic Chemicals
☐ Other Dangerous Substances

_____

_____

Delivery

Pregnancy Length: _____ Weeks
Birth Size: _____ lbs _____ oz.
Labor Length: _____ Hours
Birth Weight: _____ Inches

Complications/Medical Factors

☐ None Reported
☐ Anesthesia Used
☐ Breathing Problems
☐ Bilirubin Lights
☐ Breeched Birth
☐ Caesarean Delivery
☐ Forceps Used
☐ Other Complications
☐ Induced Labor
☐ Premature Birth (incubator)
☐ Supplemental Oxygen
☐ Other Medical Factors

_____

_____

Early Achievements/Milestones *(If early or delayed, please explain on the lines following this section)*

Turning over on his/her own	Age achieved: _____ months	☐ Unknown
Sitting up on his/her own	Age achieved: _____ months	☐ Unknown
Crawling	Age achieved: _____ months	☐ Unknown
Standing on his/her own	Age achieved: _____ months	☐ Unknown
Walking on his/her own	Age achieved: _____ months	☐ Unknown
Speaking first work	Age achieved: _____ months	☐ Unknown

_____

_____

_____

Feeding & Weaning

In infancy/childhood, was the child breast-fed? ☐ Yes ☐ No ☐ Uncertain

In infancy/childhood, was the child bottle-fed? ☐ Yes ☐ No ☐ Uncertain

Complications/difficulties: ☐ Unknown

_____

_____

Other problems in infancy: ☐ Unknown

_____

_____

Self Regulation

When did day-time toilet training occur? _____ Months

When did night-time toilet training occur? _____ Months

After toilet trained, did bed-wetting continue to occur? ☐ Yes ☐ No ☐ Uncertain

If so, when did it stop? _____ Months

After toilet trained, did bed-soiling continue to occur? ☐ Yes ☐ No ☐ Uncertain

If so, when did it stop? _____ Months

Physical Injuries & Significant Stressors *(If "yes" to either, please explain on the lines following this section)*

Has the child experienced significant injuries (head injuries, loss of consciousness, etc.)?

☐ Yes ☐ No ☐ Uncertain

Were there any major changes/stressors during patient's infancy/childhood?

☐ Yes ☐ No ☐ Uncertain

_____

_____

_____

CLIENT NAME: _____ CLIENT DOB: _____

BEHAVIOR CHECKLIST

Behavior	Mild	Moderate	Severe	In Past	Not Applicable
Alcohol/Drug Abuse	O	O	O	O	O
Anger/Outbursts of Anger	O	O	O	O	O
Anxiety/Over Sensitivity	O	O	O	O	O
Argues with Adults/Authorities/Teachers	O	O	O	O	O
Argues with Friends/Peers/Siblings	O	O	O	O	O
Avoids/Dislikes Being Touched	O	O	O	O	O
Bed Soiling/Bed Wetting (After Age 5)	O	O	O	O	O
Biting Others	O	O	O	O	O
Biting Fingernails	O	O	O	O	O
Breaking/Disregarding Curfew	O	O	O	O	O
Chewing/Sucking/Pulling/Twirling on Hair	O	O	O	O	O
Constant Activity/Motion	O	O	O	O	O
Constant Chatter/Talking	O	O	O	O	O
Criminal Behavior/Juvenile Delinquency	O	O	O	O	O
Cruelty Toward Animals/Living Things	O	O	O	O	O
Deep Sadness/Depression	O	O	O	O	O
Destruction of Property	O	O	O	O	O
Difficulty Completing Tasks	O	O	O	O	O
Difficulty Concentrating/Focusing	O	O	O	O	O
Difficulty Following Directions	O	O	O	O	O
Difficulty Keeping/Making Friends	O	O	O	O	O
Dishonest/Doesn't Tell the Truth	O	O	O	O	O
Easily Distracted	O	O	O	O	O
Easily Frustrated/Irritated	O	O	O	O	O
Engaging in Fantasies	O	O	O	O	O
Engaging in Repetitive Behaviors	O	O	O	O	O
Explosive Rage	O	O	O	O	O
Extreme Distress	O	O	O	O	O
Extreme Shyness	O	O	O	O	O
Failed School Year	O	O	O	O	O
Fighting with Friends/Peers/Siblings	O	O	O	O	O
Headache/Nausea/Stomach Aches	O	O	O	O	O
Inability to Sit Still/Restless	O	O	O	O	O
Isolates/Withdrawn from Others	O	O	O	O	O

Behavior	Mild	Moderate	Severe	In Past	Not Applicable
Fire Setting	O	O	O	O	O
Gang-Involvement	O	O	O	O	O
Lost in Day Dreams/Thoughts	O	O	O	O	O
Mood Swings	O	O	O	O	O
Nightmares/Night Terrors	O	O	O	O	O
Problems Learning	O	O	O	O	O
Problems with Mathematics	O	O	O	O	O
Problems with Motor-Coordination	O	O	O	O	O
Problems Reading/Writing	O	O	O	O	O
Problems with Speech	O	O	O	O	O
Refusal to Follow Directions	O	O	O	O	O
Refusal to Speak (Mute)	O	O	O	O	O
Self Harm (Cutting Oneself, etc.)	O	O	O	O	O
Sleepwalking	O	O	O	O	O
Sleep Problems	O	O	O	O	O
Stares into Space/Vacant Look	O	O	O	O	O
Stealing/Theft	O	O	O	O	O
Suicide Thoughts	O	O	O	O	O
Temper Tantrums	O	O	O	O	O
Threatening Adults/Authorities/Teachers	O	O	O	O	O
Threatening Friends/Peers/Siblings	O	O	O	O	O
Unhappiness	O	O	O	O	O
Verbally Abusive	O	O	O	O	O
Violent with Others	O	O	O	O	O
Manipulative	O	O	O	O	O
Running Away	O	O	O	O	O
Weight Gain/Weight Loss	O	O	O	O	O
Other	O	O	O	O	O

Key Point
HEALTH SERVICES INC.
OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

DEMOGRAPHIC INFORMATION

Client Name: _____ Date: _____

Parent/Legal Guardian Name: _____

Address: _____

Email Address: _____

Cell #: _____ Other#: _____

Date of Birth: _____ Social Security #: _____

Race: _____ Marital Status: _____

School: _____ Grade: _____

Primary Care Physician: _____

Address: _____

Phone #: _____ Fax #: _____

Previous Mental Health Providers: _____

_____

Referral Source: _____

EMERGENCY CONTACT

In the event of identified potential risk, Key Point Health Services staff members will make every effort to ensure that clients are transported to the closest emergency room for evaluation to determine if a more intensive level of services is appropriate. Please list an emergency contact below.

Name: _____

Relationship to Client: _____

Address: _____

Cell #: _____ Other #: _____

OPTUM DATA CAPTURE

Client Name _____ Today's Date _____

What do you prefer to be called? _____

Please list any previous names (ex. Maiden name) _____

Mailing Address _____

County of Residence _____

Living Situation _____

Maryland Residency _____ Yes _____ No

U.S. Citizenship _____ Yes _____ No

Does the consumer have a legal guardian? _____ Yes _____ No

Parent/Guardian/Social Services/Juvenile Services Contact Information:

Guardian First Name _____

Guardian Last Name _____

Guardian Address _____

Guardian City/State/ZipCode _____

Guardian Phone Number _____

Member Additional Details:

Ethnicity – is the individual Hispanic, Latino or Spanish origin? ____ Yes ____ No

Race __ White __ American Indian/Alaskan Native __ Black/African American
__ Asian __ Native Hawaiian/Other Pacific Islander

"Primary Language" How well do you speak English?
____Very Well ____ Well ____ Not Well ____ Not at all

Does the Individual need assistance with communicating in English? __Yes __ No

Do you speak a language other than English at home? (5 years old or older)
___ Yes ___ No ___ Not Available If yes, which language? _____

Employment Status:
___ Full-Time ___ Part-Time ___ Retired ___ Disabled ___ Homemaker
___ Student ___ Institutional/Incarcerated ___Volunteer
___ Other unemployed/Not Seeking Work ___ Other unemployed/Seeking Work

Primary Source of Income:
___ Wages/Salary ___ Public Assistance/TCA ___ Self Employment
___ Retirement/Pension ___ Unemployment Compensation ___Disability
___ Other ___ Unknown

Type of Insurance:
___ No Healthcare Coverage ___ Medicaid (Healthchoice)
___ Medicaid (Other than Healthchoice) ___ Medicare

Client insurance eligibility status: ___ Medicaid ___ Uninsured

Educational Level (Highest level of school completed): _____

Current Grade Level: _____

Marital Status: ___Single ___ Married ___ Separated ___ Divorced
___ Widow/Widower ___ Not Available

Pregnancy: ___ Yes ___ No ___ Not Available

Arrest Status/History (Number of arrests within the past 30 days- [0-96 Numerical values from 0 through 96]; 97 = Unknown
_____

"Military/Veteran status – Is this consumer a Veteran?"
___ Yes ___ No ___ Not Available

Disability Status:
Are you deaf or do you have serious difficulty hearing?
___ Yes ___ No
Are you blind or do you have difficulty seeing, even when wearing glasses?
___ Yes ___ No
Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions? (5 years old or older)
___ Yes ___ No
Do you have serious difficulty walking or climbing stairs? (5 years old or older)
___ Yes ___ No
Do you difficulty dressing or bathing? (5 years old or older)
___ Yes ___ No
Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)
___ Yes ___ No

Number of times in Self-help support group in the past 30 days: _____

Reason for Disenrollment/Discharge: (TO BE COMPLETED BY KEY POINT)
_____
_____
_____

HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

CONSENT FOR TREATMENT

Client Name: _____ DOB: _____

I am giving permission to Key Point Health Services, Inc., (KPHS) to provide outpatient mental health services to me/my child. I understand that an assessment will be completed by a licensed clinician to help identify my/my child's specific needs prior to treatment which may include individual, family and/or group psychotherapy. All clients will work with a therapist who will be responsible for service coordination. Clients may be evaluated by a prescriber for the purpose of providing diagnostic confirmation and medication assessment. If medications are considered, I understand that I will be informed of the purpose of such and of any possible risks involved. In the case of an emergency, I authorize the staff of KPHS to provide any and all necessary emergency medical treatment. I am aware that all services are provided under clinical supervision.

My signature below indicates that I have been familiarized with the premises; given information about services provided and that I have received a copy of and understand the following policies and procedures:

- Client Rights & Responsibilities & Grievance Procedure
- Crisis Intervention Services
- Health and Safety Policy
- Maryland Advance Directive
- Notice of Privacy Practices
- Procedures for Discharge & Civility Policy

The following section is only to be completed if a Parent or Legal Guardian is providing consent for treatment in lieu of the above individual.

- I am legally authorized to consent for treatment as the client's (check one):
  - ☐ Parent(s)
  - ☐ Legal Guardian(s)
- I have provided photo identification and one of the following supporting legal documents (check one):
  - ☐ Birth Certificate
  - ☐ Court Order
  - ☐ Consent for Health Care Affidavit
  - ☐ Other: _____

_____ _____
Client/Parent/Legal Guardian Name (Print) Date

_____ _____
Client/Parent/Legal Guardian Signature Date

HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

FINANCIAL INFORMATION

Client Name: _____ DOB: _____

Primary Insurance

Type of Insurance: □ Medical Assistance □ Medicare □ Tricare □ Uninsured Span
□ Other _____

Policy Holder Name: _____ Member ID: _____

Secondary Insurance

Type of Insurance: □ Medical Assistance □ Medicare □ Tricare □ Uninsured Span
□ Other _____

Policy Holder Name: _____ Member ID: _____

- I certify that the information given above is correct to the best of my knowledge.
- I understand that in some cases Key Point Health Services, Inc. (KPHS) may not be aware of fees until after my insurance company has been billed and KPHS receives payment.
- I understand that any insurance issues I may have are between me and my insurance company.
- I understand that if I acquire Medicare insurance at any time and fail to provide KPHS with my Medicare information as soon as possible I will be responsible for all fees not paid by Medicare during this time.
- I understand that the state of Maryland requires all individuals 65 years of age and older to apply for Medicare benefits.
- I hereby authorize payment directly to KPHS of the insurance benefits otherwise payable to me but not to exceed the charges for the services rendered.
- I understand that payment is due at the time of service unless prior arrangements have been made and that failure to remit payment may result in discontinuation of services.
- It is my responsibility to notify KPHS of any changes to my insurance.
- I understand that KPHS may bill my insurance company as a courtesy to me however if the insurance company denies claims or changes my co-pay amount, I am responsible for all fees not otherwise reimbursed.
- I understand that KPHS may contact my insurance company and/or employers for verification of eligibility and benefits and information regarding diagnosis and anticipated services may be provided for the purpose of reimbursement.
- I understand that I am required to provide financial information for a carrier to cover services provided to me and if I have not provided the appropriate information as of this date KPHS may charge me the normal and customary fee as determined at the time services are provided.

_____ _____
Client/Parent/Guardian Signature Date

_____ _____
Witness (KPHS Staff) Signature Date

HEALTH SERVICES INC.
OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

CIVILITY POLICY

In order to promote a safe and respectful environment at Key Point, this clinic has instituted a Civility Policy. If a client, client's guardian, or client's guest exhibits behavior found to be offensive to any staff person, clients, or visitors the following measures will be utilized:

- The individual will receive a verbal warning from Key Point personnel.
- Should the behavior continue, the individual will be asked to leave the premises
- If the individual refuses to leave, the police may be called.
- Rude and/or hostile behavior by clients or their parent(s)/guardian(s) will not be tolerated and may lead to discharge.

Behavior considered offensive is defined as including, but not limited to, verbal abuse, physically/verbally threatening others, refusal to wait patiently for the prescriber or therapist, showing disrespect to others i.e. cutting in line, speaking over someone, loud/obscene speech in waiting room or provider offices, creating confrontation or commotion unnecessarily. If you are unsatisfied with the service you receive, please request to speak to a supervisor. If you are still not satisfied, a grievance may be filed in writing with the Clinic Director.

PROCEDURES FOR DISCHARGE

Termination of services shall, whenever possible, be a collaborative process between the client and therapist. A written discharge plan including referrals and conditions for readmission will be provided to clients. Key Point will provide clients with 30 days notice of discharge to help facilitate transition. The following are potential reasons for discharge:

- Missing more than one appointment with a prescriber
- Failure to adhere to treatment recommendations or attendance contracts

Clients will not receive 30 day notice and services will be terminated immediately for any of the following reasons:

- Failure to attend a psychosocial assessment or psychiatric evaluation
- Threatening behavior or harassment including, but not limited to, verbal, sexual, or physical actions, intimidating behavior, excessive phone calls, cyber stalking, gift giving, or suggestive comments
- Boundary violations including, but not limited to, stalking, inappropriate contact.
- Misuse of medications or prescriptions including, but not limited to, violation of any federal or state law.

Client/Parent/Legal Guardian Name (Print) _____ Date _____

Client/Parent/Legal Guardian Signature _____ Date _____

HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

NOTICE OF PRIVACY PRACTICES

Client Name: _____ DOB: _____

This notice describes how your medical information may be used and disclosed and how you can obtain access to this information. Please read this notice carefully. Key Point Health Services, Inc. (KPHS) may use and disclose your Protected Health Information (PHI) in accordance with applicable law as of May 2016. KPHS is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. KPHS reserves the right to change the terms of the Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. KPHS may disclose your PHI after you have given consent by completing a written authorization. You may revoke an authorization for disclosure of your PHI at any time, except to the extent that we have already made a disclosure based upon your authorization.

PHI may include, but is not limited to, the following:

- Demographic information including names, addresses, birth date, social security number, and phone/fax numbers
- Medical record information including account/record numbers and health insurance beneficiary numbers
- Full face photographic images and any comparable images
- Medical Records

Applicable law and ethical standards may permit the disclosure of information about you without your authorization regarding the following:

- Suspected Abuse or Neglect
- Judicial and Administrative Proceedings
- Deceased Clients
- Medical Emergencies
- Health Oversight
- Law Enforcement and Community Forensic Aftercare Program
- Specialized Government Functions
- Public Health and Safety
- Treatment Coordination between Key Point programs

You have the following rights regarding your PHI:

- To inspect and copy PHI that is maintained in a "designated record set." Your right to inspect and copy PHI may be restricted in situations where there is compelling evidence that access would cause serious harm to you. KPHS may charge a reasonable, cost-based fee for copies.
- To request that KPHS amend your PHI.

- To request an accounting of disclosures that are made of your PHI. KPHS may charge you a reasonable fee.
- To request a restriction on the use or disclosure of your PHI.
- To request that KPHS communicate with you about health matters in a certain way or at a certain location.
- If there is a breach of unsecured PHI concerning you, KPHS may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- You have the right to a copy of this notice.

- To file a complaint, if you believe your privacy rights have been violated, in writing including your name and contact information to info@keypoint.org, Key Point Health Services, Attention: Chief of Operations, 135 N. Parke Street, Aberdeen, MD 21001, or The Secretary of Health and Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201.

_____ _____

Client/Parent/Guardian Signature Date

_____ _____

Witness (KPHS Staff) Signature Date