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

DEMOGRAPHIC INFORMATION

Client Name: _____ Date: _____

Parent/Legal Guardian Name: _____

Address: _____

_____

Cell #: _____ Other#: _____

Date of Birth: _____ Social Security #: _____

Race: _____ Marital Status: _____

School: _____ Grade: _____

Primary Care Provider: _____

Address: _____

Phone #: _____ Fax #: _____

Previous Mental Health Providers: _____

_____

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 #: _____