HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

DEMOGRAPHIC INFORMATION

Client Name: _____ DOB: _____

Preferred Name (if different): _____

Parent/Legal Guardian Name: _____

Address: _____

Email Address: _____

Cell #: _____ Other #: _____

Marital Status: _____ Social Security #: _____

Race: _____ Sex at Birth: _____

Gender Identity: _____ Pronouns: _____

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 _____

Medicaid ID #: _____

Client DOB _____ Diagnosis _____

Individual – General and Guardian Information

What does the Individual prefer to be called? _____

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

Mailing Address (If different from the one on file), Phone and E-Mail

Address Line 1 _____

Address Line 2 _____

City _____

State _____

Zip Code _____

Phone Number _____ Phone Type _____

E-Mail _____

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 _____

Ethnicity & Race

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

If the Individual is Multiracial, Select Other Race(s)

___ White ___ American Indian/Alaskan Native ___ Asian ___Native Hawaiian/Pacific Islander

Language

How well does the Individual speak English? (5 years or older)

_____Very Well _____ Well _____ Not Well _____ Not at all

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

Does the Individual speak a language other than English at home? (5 years old or older)

___ Yes ___ No ___ Not Available If yes, which language? _____

Marital Status and Pregnancy

Marital Status: ___Single ___ Married ___ Separated ___ Divorced

___ Widow/Widower ___ Not Available

Pregnancy: ___ Yes ___ No ___ Not Available If yes, Due Date_____

Education

Educational Level (Highest level of school completed): _____

Did the Individual attend school any time in the past 3 months?

_____ Yes _____ No If yes, Current Grade Level_____

Military/Veteran Status

Is this individual a Veteran?

_____ Yes _____ No

If Yes, Which War is the Individual a Veteran of (if More than 1, Note Most Recent)

___ Afghanistan ___ Iraq _____ None _____ Other

Specify the Time Frame for Individual's Military Service

_____Never in Military ___ Veteran- in combat less than 6 months ago

___ Veteran- in combat 6-12 months ago ___ Veteran- in combat more than 12 months ago

___On Active Duty ___Veteran- Never in combat

Would the Individual Like to be Contacted by the Office of Maryland's Commitment to Veterans for the Purpose of Veteran Benefits?

___Yes ___No ___Already in Contact ___Unknown

Disability Status

Is the Individual deaf or hard of hearing? _____ Yes _____ No

Is the Individual blind or having serious difficulty seeing, even when wearing glasses?

_____ Yes _____ No

Because of a physical, mental or emotional condition, is the individual having serious difficulty concentrating, remembering or making decisions? (5 years old or older)

_____ Yes _____ No

Is the Individual having serious difficulty walking or climbing stairs? (5 years old or older)

_____ Yes _____ No

Is the Individual having difficulty dressing or bathing? (5 years old or older)

_____ Yes _____ No

Because of a physical, mental or emotional condition, is the Individual having serious difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)

_____ Yes _____ No

Other Information

What is the Individual Living Arrangement?

____ Private Residence ____ Foster Home ____ Residential Care ____ Crisis Residence

____ Children's Residential ____ Treatment ____ Institutional Setting

____ Jail/Correctional Facility ____ Homeless/Shelter ____ Other

Was the Individual homeless in the last 6 months? _____ Yes _____ No

Employment Status:

___ Full-Time ___ Part-Time ___ Retired ___ Disabled ___ Homemaker

___ Student ___ Institutional/Incarcerated ___Volunteer

___ Other unemployed/Not Seeking Work ___ Other unemployed/Seeking Work

Tobacco use in the past 30 days? _____ Yes _____ No

Does the Individual smoke cigarettes? _____ Yes _____ No

Was the Individual screened for gambling? _____No _____ Yes – Gambling Problem Not Indicated

_____Yes-Gambling Problem Included in Treatment Here

_____Yes- Referred to Gambling Treatment elsewhere

Type of Insurance:

___ No Healthcare Coverage ___ Medicaid (Healthchoice)

___ Medicaid (Other than Healthchoice)

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

Number of arrests within the past 30 days: _____

Number of dependent children: _____

Primary source of income

_____ Wages/Salary _____ Public Assistance/TCA _____ Self-Employment

_____ Retirement _____ Unemployment Comp _____ Disability

_____ Other _____ Unknown

Individual – Substance Use Information

Please confirm individual's substance use history

_____ No, individual does not have history of SUD

_____ Yes, individual has history of SUD

If yes,

Primary Substance of Use_____ Age at First Use_____

Route of Administration: _____Not Applicable ___Oral _____Smoking ____Inhalation

____Injection ___Other

Frequency of Use _____No Use Past Month ___1-3 Times in the past Month

____1-2 Time in the Past Week ____3-6 Time in the Past Week ___Daily ____Not Applicable

Date last used_____

Expected source of payment: _____BHA Grant/Uninsured ___Medicaid ____Non-Managed Private

Insurance ____Out of Pocket Payment ____Other Funds ___Other ___Drug Court ___Unknown

____Not collected

Psych problem in addition to alcohol or drug

____Yes ____No ____Not Applicable

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.

HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

- 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

HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

CRISIS INTERVENTION SERVICES

ALL HOTLINES BELOW ARE ANSWERED 24-HOURS A DAY/7 DAYS PER WEEK UNLESS OTHERWISE NOTED

Jurisdiction	Mobile Crisis Team or Hotline	Contact Number
Statewide	Emergency number	9-1-1
	Statewide Maryland Crisis Hotline	1-800-422-0009
	National Suicide Prevention Hotlines:	1-800-SUICIDE or 1-800-273-TALK (784-2433) (-8255)
	Veterans Crisis Line:	1-800-273-8255, press 1
	Maryland Crisis Online Chat	www.Help4MDYouth.org (available Mon. - Fri., 4pm - 9pm)
Allegany	Family Crisis Resource Center	301-759-9244
		211
	Frederick County Crisis Hotline Services:	301-662-2255
	Mental Health Association of Frederick County	
	Western Maryland Regional Mental Center Hotline	240-964-1359
Anne Arundel	Anne Arundel County Crisis Response	410-768-5521
	YWCA Sexual Assault Crisis Center	410-222-7273
	YWCA Domestic Violence Hotline	410-222-6800
Baltimore City	Baltimore's Crisis, Information and Referral (CI&R) Line	410-433-5175
Baltimore County	Baltimore County Crisis Response System (Affiliated Sante)	410-931-2214
Calvert	Calvert County Health Department	410-535-1121
		301-855-1075
		Teen Line- 410-257-2216
	Walden Behavioral Health Hotline	301-863-6661
Carroll	Maryland Crisis Hotline	1-800-422-0009
Cecil	Cecil County Domestic Violence and Rape Hotline	410-996-0553
	Life Crisis Center Hotline	410-749-HELP (-4357)
		211
	Eastern Shore Operations Center (ESOC) (Affiliated Sante)	888-407-8018
Charles	Walden Behavioral Health Hotline	301-863-6661
	Center for Abused Persons (CAP)	301-645-3336
Frederick	Frederick County Crisis Hotline Services:	301-662-2255
	Mental Health Association of Frederick County	
		211
Garrett	Frederick County Crisis Hotline Services:	301-662-2255
	Mental Health Association of Frederick County	
		211
Harford	Harford County Mobile Crisis (Affiliated Sante)	1-800-NEXT-STEP (-639-8783)
	Sexual Assault/ Spouse Abuse Resource Center, Inc.	410-836-8430
Howard	Grassroots Crisis Intervention	410-531-6677 (24/7 hotline & mobile crisis team)
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's and Talbot Cos.)	Eastern Shore Operations Center (ESOC) (Affiliated Sante)	888-407-8018
	For All Seasons, Inc. (Rape Crisis Center)	1-800-310-7273
	Life Crisis Center Hotline	410-749-HELP (-4357)
		211
	Mid-Shore Council on Family Violence	1-800-927-HOPE (-4673)
Montgomery	Montgomery County Crisis Center	240-777-4000
	Everymind, - Montgomery Country Hotline	301-738-CALL (-2255)
Prince George's	Community Crisis Services, Inc.	301-864-7100
	Prince George's County Crisis Response System	301-429-2185
	Family Crisis Center of Prince George's County (Domestic Violence)	301-731-1203
Saint Mary's	Walden Behavioral Health Hotline	301-863-6661
Somerset	Life Crisis Center Hotline	410-749-HELP (-4357)
		211
	Eastern Shore Operations Center (ESOC) (Affiliated Sante)	1-888-407-8018
Washington	Frederick County Crisis Hotline Services:	301-662-2255
		211
Wicomico	Life Crisis Center Hotline	410-749-HELP (-4357)
		211
	Eastern Shore Operations Center (ESOC) (Affiliated Sante)	1-888-407-8018
Worcester	Life Crisis Center Hotline	410-749-HELP (-4357)

HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

CLIENT RIGHTS & RESPONSIBILITIES

You have the right:

- To expect privacy and dignity in treatment consistent with providing you with good care
- To receive considerate, respectful care at all times and under all circumstances
- To expect prompt and reasonable responses to your questions
- To know the identity and professional status of your provider(s)
- To request and receive your medical record according to Clinic Policy
- To be informed of your condition, proposed treatment, and associated risks and benefits
- To discontinue treatment at any time
- To receive impartial access to treatment regardless of race, gender identity, creed, sexual orientation, national origin, religion, physical handicap or sources of payment.
- To participate in the decision-making process related to your treatment plan
- To exercise your cultural values and spiritual beliefs as long as they do not interfere with the well-being of others
- To participate in the discussion of ethical issues that arise
- To express concerns regarding any of these rights by following the grievance procedure
- To formulate an Advanced Directive

You are responsible for:

- Providing accurate and complete information about present and past medical conditions
- Reporting unexpected changes in your condition to your provider(s)
- Meeting with your provider to develop a treatment plan at least every six months
- Informing your provider(s) whether or not you understand your treatment plan
- Adhering to the objectives outlined in the treatment plan
- Scheduling and attending appointments, and if you cannot, notifying the proper person
- Being considerate of other clients and Key Point Staff

GRIEVANCE PROCEDURE

- If you have concerns about the care that you or your family member has received, we encourage you to speak directly with the staff member involved.
- If you have not found resolution, you may contact the staff member's supervisor.
- If efforts to resolve a complaint are still unsatisfactory, you may contact the Clinic Director in writing. You will receive a response within 3 days.

HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

HEALTH AND SAFETY POLICY

Key Point strictly prohibits the client recording the therapist and/or session in any form. This includes video and/or audio monitoring with or without the therapist's knowledge or consent. Recording of the session by the therapist may only be done with written consent of the client and only for purposes of training or development.

Each employee is expected to follow safety rules and to exercise caution and prudence in all work related activities. Specifically prohibited anywhere on KPHS property at any time are weapons of any kind, shape, or size, including but not limited to items such as firearms, knives, mace, pepper spray, etc. KPHS intends to maintain a healthful environment. This includes attempting to limit the exposure and spread of pests of significant public health importance including, but not limited to, bedbugs, lice, and various microorganisms. Accordingly, individuals may be asked to refrain from entering KPHS property until the risk of exposure and spread is minimized. The use of any tobacco product is prohibited anywhere on KPHS property, except for designated areas, at any time. The sale, use, possession or distribution of drugs (including prescription medications) or alcohol on KPHS property or while performing company business is prohibited at all times. Clients are encouraged to take unused and expired prescription medications to the local police station for disposal. Medications may also be given to prescribers for disposal. KPHS does not use restraint or seclusion when interacting with clients or the community.

- If a client or community member is found in violation of the policy the individual may receive a verbal warning from Key Point personnel or be asked to leave the premises. If the individual refuses to leave, the police may be called.
- Medications may be given to prescribers to add to Key Point's quarterly burn disposal of unused and expired medication or flushed down the toilet.
- All instances of client policy violation will be discussed by the treatment team and a decision will be made to determine if the client may remain in services.

KeyPoint
HEALTH SERVICES INC.
OUTPATIENT MENTAL HEALTH PROGRAMS

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

ADULT HEALTH HISTORY - MEDICAL

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

Eyes, Ears, Nose, Throat

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

_____

_____

Musculoskeletal

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

_____

_____

Blood/Lymphatic System

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

_____

_____

Circulatory/Cardiac Systems

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

_____

_____

Endocrine System

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

_____

_____

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

**Any questions that do not apply please leave blank:*
*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

ADULT 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

ADULT 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

Client Name: _____ Date: _____

SA-46 Questionnaire

Depression

	1–Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Feeling low in energy or slowed down	○	○	○	○	○
Poor Appetite (or over eating)	○	○	○	○	○
Feeling no interest in things	○	○	○	○	○
Feeling everything is an effort	○	○	○	○	○
Thoughts of death or dying	○	○	○	○	○
Thoughts of ending your life	○	○	○	○	○
Loss of pleasure or sexual interest	○	○	○	○	○
Trouble concentrating or remembering	○	○	○	○	○
Crying easily	○	○	○	○	○
Worrying too much about things	○	○	○	○	○
Trouble falling asleep	○	○	○	○	○
Awakening in the early morning	○	○	○	○	○
Sleep that is restless or disturbed	○	○	○	○	○
Feeling hopeless about the future	○	○	○	○	○
Feelings of guilt	○	○	○	○	○
Feelings of worthlessness	○	○	○	○	○
Sub-Score Total					

Comments

Anxiety-Panic

	1–Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Nervousness or shakiness inside	○	○	○	○	○
Suddenly scared or fearful for no reason	○	○	○	○	○
Heart pounding or racing	○	○	○	○	○
Feeling tense or keyed up	○	○	○	○	○
Spells of terror or panic	○	○	○	○	○
Feeling so restless you couldn't sit still	○	○	○	○	○
Sub-Score Total					

Comments

Phobia-Fear

	1–Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Feeling afraid to go out of your house alone	○	○	○	○	○
Feeling afraid in open spaces or on the streets	○	○	○	○	○
Having to avoid certain things, places, or activities because they frighten you	○	○	○	○	○
Feeling uneasy in crowds, such as shopping or at a movie	○	○	○	○	○
Feeling afraid to travel on buses, subways, or trains	○	○	○	○	○
Sub-Score Total					

Comments

Client Name: _____ Date: _____

Anger-Irritability

	1–Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Feeling easily annoyed or irritated	○	○	○	○	○
Temper outburst that you could not control	○	○	○	○	○
Shouting or throwing things	○	○	○	○	○
Getting into frequent arguments	○	○	○	○	○
Having urges to beat, injure, or harm someone	○	○	○	○	○
Having urges to break or smash things	○	○	○	○	○

Sub-Score Total

Comments

Psychotic-Like

	1–Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Hearing voices that other people do not hear	○	○	○	○	○
The idea that someone else can control your thoughts	○	○	○	○	○
Having thoughts that are not your own	○	○	○	○	○
Other people being aware of your private thoughts	○	○	○	○	○
The idea that something is wrong with your mind	○	○	○	○	○
Feeling that you are watched or talked about by others	○	○	○	○	○

Sub-Score Total

Comments

Obsessive-Compulsive

	1–Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Unwanted thoughts, words or ideas that won't leave your mind	○	○	○	○	○
Having to check and double-check what you do	○	○	○	○	○
Having to repeat the same actions-touching, counting, washing	○	○	○	○	○
Difficulty making decisions	○	○	○	○	○
Your mind goes blank	○	○	○	○	○
Feeling blocked in getting things done	○	○	○	○	○
Having to do things very slowly to ensure correctness	○	○	○	○	○

Sub-Score Total

Comments