KEY POINT HEALTH SERVICES

CRISIS INTERVENTION SERVICES AND RESOURCES

National:

- Suicide and Crisis Lifeline: Call or Text 988
- National Domestic Violence Hotline: Call 1-800-799-7233
- SAMHSA's National Helpline: Call 1-800-662-HELP (4357) or Text your Zip Code to 435748
- National Substance Abuse Hotline: Call 1-866-411-6803
- National Council on Alcoholism and Drug Dependence: Call 1-800-622-2255
- Partnership at DrugFree.org: Call 1-855-378-4373
- Alcoholics Anonymous: Call 212-870-3400
- Disaster Distress Helpline: Call 1-800-985-5990
- Veterans Crisis Line: Call 988, then press 1 or Text 838255
- Crisis Text Line: Text HOME to 741741
- National Sexual Assault Hotline: Call 1-800-656-4673
- The Trevor Project For LGBTQ Youth: Call 1-866-488-7386 or Text 'START' to 678-678
- The Trans Lifeline: Call 1-877-565-8860
- National Human Trafficking Hotline: Call 1-888-373-7888 or Text 233733
- National Call Center for Homeless Veterans 1-877-4AID VET (877-424-3838)
- NAMI HelpLine: Call 1-800-950-NAMI (6264) or Text NAMI to 62640
- NAMI Teen & Young Adult HelpLine: Text Friend to 62640

Local:

- Maryland Crisis Hotline: Call 1-800-422-0009
- Anne Arundel County:
    - Anne Arundel County Crisis Warmline: Call 410-768-5522
- Baltimore City:
    - Baltimore Crisis Response, Inc: Call 410-433-5175
    - House of Ruth 24 Hotline for Domestic Violence: Call 410-889-7884
    - Family Crisis Services Advice/Help Hotline: Call 410-828-6390
- Baltimore County:
    - Baltimore County Crisis Response: Call 410-931-2214
    - Postpartum Depression Hotline: Call 1-800-773-6667
    - Sexual Assault and Domestic Violence Help: Call 410-828-6390
- Cecil County:
    - Eastern Shore Crisis Response: Call 1-888-407-8018
    - Cecil County Domestic Violence and Rape Hotline: Call 410-996-0333
    - Cecil Addiction Treatment Coordination Hotline (CATCH): Call 443-245-3257
- Harford County:
    - Klein Family Center: Call 1-800-NEXT STEP (639-8783)
    - SARC Domestic Violence Helpline: Call 410-836-8430

KEY POINT
HEALTH SERVICES

CLIENT RIGHTS & RESPONSIBILITIES

You have the right:

- To expect privacy and dignity in treatment, consistent with providing you quality clinical care.
- To always receive considerate and respectful care 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 services 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 and goals.
- 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 for mental health.

You are responsible for:

- Providing accurate and complete information about present and past medical conditions.
- Participating in a three-part, initial diagnostic evaluation, that includes meeting with a therapist and a psychiatrist or psychiatric nurse practitioner.
- Reporting unexpected changes in your condition to your provider(s).
- Meeting with your therapist at least every 90 days, and meeting in person to develop a treatment plan, a minimum of every six months.
- Meeting with your prescriber at least annually, or a minimum of every 90 days if you're being prescribed psychiatric medications.
- Informing your provider(s) whether you understand your treatment plan.
- Adhering to the objectives outlined in the treatment plan and following clinical recommendations from your provider(s).
- Scheduling and attending appointments, and if you cannot, notifying the proper person.
- Being considerate of other clients and Key Point Staff.

KEY POINT
HEALTH SERVICES

HEALTH AND SAFETY POLICY

Key Point strictly prohibits a client or parent/guardian recording their provider(s), office, and/or session in any form. This includes video and/or audio monitoring with or without the provider's knowledge or consent. Recording of the session by the therapist may only be done with written consent of the client or parent/guardian 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 healthy environment. This includes attempting to limit the exposure and spread of illness and/or 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 outside areas. The sale, use, possession or distribution of drugs (including prescription medications) or alcohol on KPHS property or while performing company business is always prohibited.

- 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 (flushed down the toilet or added to Key Point's quarterly burn disposal of unused and expired medication).

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.
- 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.

CIVILITY POLICY

To promote a safe and respectful environment Key Point has instituted a Civility Policy. If an individual exhibits behavior found to be in violation of the policy, whether in person, virtually, or over the telephone, the following measures will be utilized:

- The individual will receive a verbal warning from Key Point personnel.
- Should the behavior continue, contact will be terminated, and if physically present, 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 and the inability to return to treatment.

Behavior considered offensive is defined as including, but not limited to, verbal abuse, physically/verbally threatening others, refusal to wait patiently, audio or video recording, inappropriate language, loud or aggressive speech, showing disrespect to others. Individuals wishing to dispute the civility policy violation will be directed to follow the grievance procedure.

KEY POINT HEALTH SERVICES

PROCEDURES FOR DISCHARGE

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

- No contact with the treatment team in 90 days
- Failure to adhere to treatment recommendations or attendance contracts
- Refusal to participate in clinic services
- The need for specialized services or a higher level of care that KPHS does not provide

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

- Failure to attend an initial psychosocial assessment or psychiatric evaluation.
- Threatening behavior or harassment including, but not limited to, verbal, sexual, or physical actions, intimidation, stalking, excessive phone calls, or suggestive comments.
- Boundary violations including, but not limited to, audio or video recording, social media contact, dual relationships, inappropriate invitations or contact outside of Key Point.
- Misuse of medications or prescriptions including, but not limited to, violation of any federal or state law.

GRIEVANCE PROCEDURE

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

KEY POINT
HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES

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 laws as of the effective date of this notice. PHI may include, but is not limited to, information in your medical record such as demographic information including names, addresses, birth date, social security number, and phone/fax numbers, account/record numbers, health insurance beneficiary numbers, full face photographic images, and any comparable images. 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.

KPHS has chosen to participate in the Chesapeake Regional Information System for our Patients ("CRISP"), a regional health information exchange ("HIEs") serving Maryland. CRISP is also affiliated with and shares data with other HIEs, including those in Alaska, Connecticut, D.C., Maryland, and West Virginia. As permitted by law, your PHI will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your PHI available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program ("PDMP"), will still be available to providers.

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, medical or mental health emergencies, health oversight, law enforcement and community forensic aftercare program, specialized government functions, public health and safety, and 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", except 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 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.

KEY POINT
HEALTH SERVICES

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: _____

_____

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 #: _____

KEY POINT
HEALTH SERVICES

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 and developing a person-centered treatment plan based on assessments and the needs of the client. Therapists will work collaboratively with the client and/or family to develop goals for treatment and track achievement of goals. Clients will be evaluated by a prescriber for the purpose of providing diagnostic confirmation, medical evaluation, 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 KPHS to provide any and all necessary emergency medical treatment. I am aware that all services are provided under clinical supervision.

By signing below, I confirm that I have received information about the services provided, Advance Directives for Mental Health, and was familiarized with the premises. I also acknowledge that I have received a written copy of, understand, and agree to the following policies and procedures:

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

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 ☐ Consent for Health Care Affidavit

  ☐ Court Order ☐ Other: _____

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

_____ _____
Client/Parent/Legal Guardian Signature Date

KEY POINT
HEALTH SERVICES

FINANCIAL INFORMATION

Client Name: _____ DOB: _____

Primary Insurance

Type of Insurance: ☐ Medicaid ☐ Medicare ☐ Other _____

Policy Holder Name: _____ Member ID: _____

Secondary Insurance

Type of Insurance: ☐ Medicaid ☐ Medicare ☐ Other _____

Policy Holder Name: _____ Member ID: _____

Coverage Information

Co-Payment: ☐ Per Day ☐ Per Service Amount: _____

Deductible: _____ / _____ Remaining Coinsurance: _____

- I understand that Key Point Health Services, Inc. (KPHS) may not be aware of fees until after my carrier has been billed and payment is received and any insurance issues I may have are between me and my insurance carrier.
- I understand that I must notify KPHS of any change to my coverage and that if I fail to provide updated information, I will be responsible for all fees not otherwise reimbursed.
- I understand that the state of Maryland requires all people aged 65 or older to apply for Medicare.
- I understand fees may be billed under a different provider, who supervises services, as authorized by my carrier.
- I authorize payment of insurance benefits directly to KPHS, not to exceed the charges for the services rendered, that may otherwise be payable to me.
- I understand that payment is due at the time of service; failure to remit payment may result in discontinuation of services until payment is made, if I am more than three payments behind.
- I understand that KPHS may bill my insurance carrier, however if claims are denied or co-pays or coinsurance are changed, I am responsible for all fees not otherwise reimbursed.
- I understand that I may be required to provide information for a carrier to cover services; if I have not done so, KPHS may charge me the normal and customary fee as determined at time of service.
- I understand that KPHS may contact my insurance carrier and/or employers for verification of eligibility and benefits; information regarding diagnosis and anticipated services may be provided for the purpose of reimbursement.

I understand the items above and certify that all information given is correct to the best of my knowledge.

_____ _____

Client/Parent/Guardian Signature Date

_____ _____

Witness (KPHS Staff) Signature Date

KEY POINT
HEALTH SERVICES

CONSENT FOR TELEHEALTH

Client Name: _____ DOB: _____

I am giving permission to Key Point Health Services, Inc., (KPHS) to provide therapy and/or psychiatry services to me/my child via telehealth. Telehealth means the use of interactive audio, video, or other telecommunications or electronic media by a clinician to deliver services. Telehealth does not mean an electronic email, text message, or other type of message sent between KPHS and the client. No video, audio or photo recordings will be taken of you/your child during telehealth services without your consent. Telehealth is not offered for all appointments or clients; there may be times, based on state and/or federal regulations, clinical presentation, or clinic policy, that telehealth is not recommended or available. All clients are required to attend some in-person services; KPHS does not offer telehealth-only services. Clients may choose to utilize in-person services only, in lieu of any telehealth services.

When utilizing telehealth services, I understand and agree to the following:

- I understand that I/my child must be physically located in the state of Maryland to participate in telehealth services, and I am responsible for notifying KPHS of my/my child's location.
- I understand that I will provide my/my child's own device to access telehealth services.
- I understand that I am responsible for securing privacy and safety in terms of the location where I/my child connects to the session.
- KPHS staff will explain how the telehealth services will be provided.
- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth services.
- I understand that I/my child may not audio or video record (or take photographs or screenshots) my/my child's telehealth session.
- My telehealth provider may end the visit/session if I engage in any disruptive or inappropriate behavior as determined by, and at the discretion of, the telehealth provider.
- Telehealth services will only be provided through an approved, HIPAA compliant, platform.
- I understand that technology platforms used for telehealth sometimes malfunction. The provider or I can stop a telehealth session if the technology is not working properly or if it is determined that telehealth is not appropriate for the session.
- I understand that if the session is interrupted for any reason I/my child will attempt to reconnect or call the clinic to reach my provider. In the case of an emergency, I will call 911 or utilize crisis resources and contact my provider after obtaining emergency assistance.

I have read and understand the items as defined in the above Telehealth Services Consent Form.

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

_____ _____
Client/Parent/Legal Guardian Signature Date

KEY POINT HEALTH SERVICES

SA-46

Client Name: _____ Date: _____

Please read through the following symptoms and rate each using the scale provided based on the past week of your life.

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	○	○	○	○	○
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	○	○	○	○	○
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	○	○	○	○	○
Comments:					

KEY POINT HEALTH SERVICES

Anger- Irritability	1 Not at all	2 A little bit	3 Moderately	4 Quite a bit	5 Extremely
Feeling easily annoyed or irritated	○	○	○	○	○
Temper outbursts 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	○	○	○	○	○
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	○	○	○	○	○
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	○	○	○	○	○
Comments:					

KEY POINT HEALTH SERVICES

BEHAVIOR CHECKLIST

Client Name: _____ DOB: _____

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

KEY POINT HEALTH SERVICES

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

KEY POINT HEALTH SERVICES

CHILD/ADOLESCENT HEALTH HISTORY - MEDICAL

Client Name: _____ DOB: _____

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

Eyes, Ears, Nose, Throat

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

_____
_____

Musculoskeletal

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

_____
_____

Blood/Lymphatic System

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

_____
_____

Circulatory/Cardiac Systems

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

_____
_____

Endocrine System

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

_____
_____

Gastrointestinal System

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

_____
_____

KEY POINT HEALTH SERVICES

Genital/Urinary System

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

_____
_____

Nervous System

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

_____
_____

Respiratory System

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

_____
_____

Integumentary System

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

_____
_____

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 use birth control? ☐ Yes ☐ No
Do you plan to become pregnant? ☐ Yes ☐ No
Any history of pregnancy, miscarriage or terminations? ☐ Yes ☐ No

_____

KEY POINT HEALTH SERVICES

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

**Please provide age at time of birth, not current age.*

Biological/Birth Father: ☐ Unknown

First Name: _____ Last Name:_____ *Age:_____

Biological/Birth Mother: ☐ Unknown

First Name: _____ Last Name:_____ *Age:_____

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

_____

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

_____

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

_____

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

_____

KEY POINT HEALTH SERVICES

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 there 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 ☐ Lead/Mercury ☐ Nicotine ☐ Alcohol
☐ Illicit Drugs ☐ Caffeine ☐ Toxic Chemicals ☐ Poisons
☐ Medications (prescription) ☐ Medications (OTC) ☐ Other Dangerous Substances

_____
_____
_____

Delivery

Pregnancy Length: _____ Weeks
Labor Length: _____ Hours
Birth Size: _____lbs. _____oz.
Birth Weight: _____ Inches

Complications/Medical Factors

☐ None Reported ☐ Breeched Birth ☐ Supplemental Oxygen ☐ Forceps
☐ Caesarean Delivery ☐ Premature Birth/Incubator ☐ Bilirubin Lights ☐ Anesthesia
☐ Breathing Problems ☐ Other Complications ☐ Other Medical Factors ☐ Induction

_____
_____
_____

Early Achievements/Milestones

(If early or delayed, please explain)

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

KEY POINT HEALTH SERVICES

In infancy/childhood, was the child bottle-fed? ☐ Yes ☐ No ☐ Uncertain
Complications/difficulties (please explain): ☐ Unknown

_____

_____

Other problems in infancy (please explain): ☐ Unknown

_____

_____

Self Regulation

When did day-time toilet training occur? Age achieved: _____months ☐ Unknown
When did night-time toilet training occur? Age achieved: _____months ☐ Unknown
After toilet trained, did bed-wetting continue to occur? ☐ Yes ☐ No ☐ Uncertain
If so, when did it stop? Age achieved: _____months
After toilet trained, did bed-soiling continue to occur? ☐ Yes ☐ No ☐ Uncertain
If so, when did it stop? Age achieved:_____ months

Physical Injuries & Significant Stressors

(If "yes" to either, please explain)

Has the child experienced significant injuries? ☐ Yes ☐ No ☐ Uncertain

_____

_____

Were there any major changes/stressors during infancy/childhood? ☐ Yes ☐ No ☐ Uncertain

_____

_____

Mental Health Advance Directives

An Important Tool for Empowerment and Communication

What does a mental health advance directive mean for you?

A mental health advance directive is a legal document you can complete to express your needs and preferences for mental health treatment in case you are unable to make or communicate your decisions in the future. If you are living with a serious mental illness (bipolar disorder, schizophrenia, etc.), consider completing a mental health advance directive during a period of wellness or recovery. You can communicate what types of treatment you do or do not want and appoint an individual (health care agent) to assist with your health care decisions.

Benefits of having a mental health advance directive

- Provides clear instructions about medication and treatment to guide decision making
- Improves communication between your medical, support, and treatment networks
- May help you avoid unwanted treatment or admission to a hospital
- Enhances your recovery

Your mental health advance directive can include the following:

- ✓ Preferred hospital(s) and service provider(s)
- ✓ Person(s) you have authorized to make health decisions and with whom information may be shared or not shared
- ✓ Any allergies, adverse reactions, and other health issues
- ✓ Specific treatment preferences
- ✓ Desired visitors

How to get started

Talk to your care team (psychiatrists, therapists, case workers, etc.) – they can help you complete a mental health advance directive. **You and two witnesses will need to sign the document, which is valid until you make changes or revoke it**.

For more information visit: health.maryland.gov/bha/Pages/Mental-Health-Advance-Directives.aspx