



Provider/Date _____

Name: _____

**ADULT PSYCHIATRY CLINIC – SANTA CLARA
Adult Personal Data Sheet**

MRN: _____

NAME		MEDICAL PRACTITIONER	
ADDRESS		CITY	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	
EMERGENCY CONTACT		EMERGENCY PHONE	
DATE OF BIRTH	AGE:	SEX: Female Male	SEXUAL ORIENTATION
HOW LONG HAVE YOU LIVED IN THIS AREA?	MILITARY SERVICE	Yes No	LAST SCHOOL GRADE COMPLETED:
CHECK ALL THAT APPLY: Single Married Partnered Separated Divorced ___ # of times Widowed			
LIVING WITH SPOUSE / PARTNER? Yes No		NUMBER OF YEARS LIVING TOGETHER:	
PLACE OF BIRTH	ETHNICITY	RELIGION	
OCCUPATION: How long at this type of work?		Are you currently on:	
EMPLOYER: How long at this job?		Worker's Comp?	Yes No
USUAL WORK HOURS		SSI?	Yes No
		State Disability?	Yes No
		Other?	Yes No

Major Reasons For Seeking Help At This Time

Did someone refer you to this clinic? Yes No If yes, who? _____

What brings you to our clinic at this time?

How long have you had these problems or symptoms? _____

Why did you seek help now?

What have you already tried?

What important questions and concerns would you like addressed today?

Types of help desired:

Group Therapy Substance use/abuse treatment Medication Treatment Other

Name _____

MR# _____

Check the items below that apply to your current (within the last 3 months) and past condition(s):

Current		Past	Current		Past	Current		Past
<input type="checkbox"/>	<input type="checkbox"/>	Feeling sad most of the time	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Overly elated or euphoric mood
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest or joy	<input type="checkbox"/>	<input type="checkbox"/>	Worried most days	<input type="checkbox"/>	<input type="checkbox"/>	Feeling overly irritable
<input type="checkbox"/>	<input type="checkbox"/>	Crying	<input type="checkbox"/>	<input type="checkbox"/>	Sudden feeling of terror / panic	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts racing too fast / overflowing
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue / Low energy	<input type="checkbox"/>	<input type="checkbox"/>	Scared to go outside	<input type="checkbox"/>	<input type="checkbox"/>	Limitless energy / feeling wired
<input type="checkbox"/>	<input type="checkbox"/>	Trouble falling or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	Irrational fears	<input type="checkbox"/>	<input type="checkbox"/>	Rapid mood changes
<input type="checkbox"/>	<input type="checkbox"/>	Too little or too much appetite	<input type="checkbox"/>	<input type="checkbox"/>	Avoidance of things	<input type="checkbox"/>	<input type="checkbox"/>	Fantastic thoughts or plans
<input type="checkbox"/>	<input type="checkbox"/>	Gaining or losing weight	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts that you can't stop	<input type="checkbox"/>	<input type="checkbox"/>	Doing things impulsively
<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	Doing things repetitively	<input type="checkbox"/>	<input type="checkbox"/>	Being highly distractable
<input type="checkbox"/>	<input type="checkbox"/>	Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Excessive or out-of-control spending
<input type="checkbox"/>	<input type="checkbox"/>	Feeling worthless	<input type="checkbox"/>	<input type="checkbox"/>	Feeling restless	<input type="checkbox"/>	<input type="checkbox"/>	Reduced need for sleep
<input type="checkbox"/>	<input type="checkbox"/>	Thinking of killing yourself	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices others don't	<input type="checkbox"/>	<input type="checkbox"/>	Binge eating / purging
<input type="checkbox"/>	<input type="checkbox"/>	Planning a way to kill yourself	<input type="checkbox"/>	<input type="checkbox"/>	Hearing sounds others don't	<input type="checkbox"/>	<input type="checkbox"/>	Avoiding / restricting eating
<input type="checkbox"/>	<input type="checkbox"/>	Changes in sex drive	<input type="checkbox"/>	<input type="checkbox"/>	Seeing things others don't	<input type="checkbox"/>	<input type="checkbox"/>	Compulsive eating
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Feeling people plot against you	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Other sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	Others control your thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Being emotionally abused
<input type="checkbox"/>	<input type="checkbox"/>	Relationship problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Being physically abused
<input type="checkbox"/>	<input type="checkbox"/>	Work performance problems	<input type="checkbox"/>	<input type="checkbox"/>	Pain / headaches	<input type="checkbox"/>	<input type="checkbox"/>	Being sexually abused
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with coworker	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Having violent / aggressive behavior
<input type="checkbox"/>	<input type="checkbox"/>	Conflict in family	<input type="checkbox"/>	<input type="checkbox"/>	Stomach / Bowel trouble	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of physically harming someone
<input type="checkbox"/>	<input type="checkbox"/>	Financial problems	<input type="checkbox"/>	<input type="checkbox"/>	Tremors or tics	<input type="checkbox"/>	<input type="checkbox"/>	Having frequent anger / temper

Past Psychiatric History (If yes, write in type of treatment, provider name, year and if helpful)

Counseling or Psychotherapy? Yes Never	Type (Individual/Group/Family)	By Whom? (Provider)	Dates	Helpful?	
				Yes	No
Psychiatric Medication(s)? Yes Never	Name of medication and dose	By Whom? (Doctor)	Dates	Yes	No
Psychiatric Hospital Admissions? Yes Never	Where?	Why?	Dates	Yes	No

Family Psychiatric History (Psychiatric, Suicides, Substance Abuse, Medication Responses)

No known psychiatric illnesses No known suicides No known substance abuse No known medication use Unknown history

Have any family members had any problems with criminal offenses or been in jail or prison? Yes No

Name _____

MR# _____

HABITS (alcohol, street drugs, cigarette smoking, other tobacco use, gambling)

Do you use alcohol? Yes No If yes:

Within the past year, have you ever drank more than you meant to? Yes No

Within the past year, have you felt that you wanted or need to cut down on your drinking? Yes No

Did you use a program to stop? Yes No

If so, please describe: _____

Last alcohol taken (time and amount): _____

Do you use street drugs other than alcohol? Yes No If yes:

What drugs have you used within the last year? _____

Within the past year, have you ever used more drugs than you meant to? Yes No

Within the past year, have you felt that you wanted or need to cut down on your drug use? Yes No

Did you use a program to stop? Yes No

If so, please describe: _____

Last drug taken (time and amount): _____

Have you ever smoked or used other tobacco products? Yes No If yes:

What kind and how much?

When did you start? _____

When did you stop? _____

Did you use a program to stop? Yes No

If so, please describe: _____

How many cups of caffeinated beverages do you drink per day? (coffee, tea, sodas, chocolate) _____

Do you gamble? Yes No If yes:

Do you ever gamble more than you can afford to lose? Yes No

Have you ever "chased your losses," or borrowed money in order to continue gambling? Yes No

Do you feel you have a problem with gambling? Yes No

Do you engage in any other behaviors that cause you distress or problems? Yes No

If so, please describe: _____

Thank you for filling out this form.

Name _____
 MR# _____

Current Family

Name	City Residence	Check if living with you	If living, age	If deceased, age at & year of death	Occupation	How do you get along?
Spouse / partner						
Children						
Other household members						

Childhood Experiences

- How did you get along with your family during childhood?
- How many siblings did you have?
- Anything significant or negative about childhood experiences? **Yes No**
 (e.g. parents' divorce; physical, emotional, or sexual abuse or other trauma)
 Please explain:

Medical History

Do you have any serious or chronic medical conditions (including surgeries)? **Yes No**
 If so, please list:

Have you had any serious accidents or injuries? **Yes No**
 If so, please describe:

Have you ever had any head injury, or past seizures? **Yes No**

Are you currently taking any prescriptions, over-the-counter meds or herbs? **Yes No**
 If so, please list:

Have you had any allergic reactions to, or other problems with medications? **Yes No**
 If so, please describe:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Date: _____

NAME: _____ **MRN (Kaiser#):** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add columns: + +

Total:

10. If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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11. Have you been thinking about a specific way to physically harm yourself or of committing suicide in the last two weeks?	No _____	Yes _____
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Location: _____

MH #: _____
Name: _____

CONFIDENTIALITY DISCLOSURE

IMPRINT AREA

KPNC's Mental Health and Chemical Dependency Services: Your Right to Privacy

Separation of Records

Kaiser Permanente's Mental Health and Chemical Dependency (MH/CD) services are strongly committed to protecting your privacy. The Northern California Notice of Privacy provides general information about how your medical information is used and protected. Federal and state law protects the confidentiality of your records. Violation of federal confidentiality laws related to chemical dependency programs is a crime. Suspected violations may be reported to the appropriate authorities.

Except under limited circumstances (see examples below), Kaiser Permanente's MH/CD program may not, without your written permission, disclose information about your care to anyone outside of Kaiser Permanente. For your privacy, records of your MH/CD visits are kept separate from your outpatient medical record except that: for your personal safety, any medications or related laboratory results that have been prescribed as part of your MH/CD treatment are included in your medical record, either on paper or electronically. Mental Health diagnoses are only available to treating providers on a need-to-know basis.

Coordination of Care

Because MH/CD staff work as members of an integrated system of care, relevant information about your care will be exchanged among MH/CD staff as necessary. Your permission is not required to coordinate your psychiatric care with care providers within Kaiser Permanente, such as your primary care doctor. However, ordinarily we will discuss with you any necessary sharing of psychiatric information. When we share information, we only share that information which, in our professional judgment, we believe is needed for appropriate medical care by that provider. Your written authorization is normally required before any information about chemical dependency treatment can be released to anyone outside the MH/CD treatment team. A valid written authorization must specify the nature of the information to be released, identify the receiving party, and indicate when your authorization expires.

Exceptions to Confidentiality Rules

Examples of circumstances under which the law requires or permits us to release information, without your permission include:

- medical and psychiatric emergencies in which the information is essential to an individual's safety
- disclosures of information to warn potential victims of violent acts
- to qualified personnel for audit or program evaluation or research. For example, you may receive surveys from persons authorized by Kaiser Permanente to conduct surveys on its behalf.
- reporting of suspected child abuse or neglect
- to report the commission of crimes on our premises or against our program personnel
- responses to court orders in which a judge has ruled that the information is necessary for the administration of justice (42 U.S.C. Section 290dd-2 for Federal laws and 42 C.F.R. Part 2 for Federal regulations)
- reports to the Department of Motor Vehicles due to lapses of consciousness

If at any time you have concerns about your privacy, you are encouraged to request clarification from your therapist or staff member.

Acknowledgment:

By signing your name in the space below, you acknowledge that you have read and understood this document (Note: If the person receiving care is a minor, then a parent or legal guardian acknowledges having read and understood this document. Under certain circumstances, minors may consent to treatment themselves without parental permission.)

SIGNED: PATIENT'S OR REPRESENTATIVE'S DATED SIGNATURE	DATE
PRINT NAME AND RELATIONSHIP TO PATIENT (IF SIGNED BY AUTHORIZED REPRESENTATIVE OF THE PATIENT)	DATE



MR #: _____

Name: _____

CONSENT TO TREATMENT

IMPRINT AREA

Consent to Treatment

Most people who participate in behavioral or mental health treatment benefit from it. Like most kinds of health care, this kind of treatment requires a very active effort on your part if you are going to get something out of it. In addition, there may be certain kinds of risks involved. For example, the therapy process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks. In fact, sometimes there can be more risks associated with **not** participating in therapy.

If you see a physician as part of your care, he or she may prescribe medication for you. If so, you'll be advised at that time of the benefits and any risks of the medications.

It is important that you participate in this treatment willingly. If you have any questions or concerns about this document, about the services being provided to you, or about your treatment options, you should definitely ask your therapist.

Acknowledgment

By signing your name in the space below, you are acknowledging that you have read and understood this document and that you voluntarily agree to participate in this treatment. *If the person receiving care is a minor, a parent or legal guardian acknowledges having read and understood this document and voluntarily agrees to the minor's participation in the treatment (except in certain legally exempt situations).*

PATIENT'S SIGNATURE (IF SIGNATURE OTHER THAN PATIENT, LIST RELATIONSHIP)	DATE
WITNESS' SIGNATURE	DATE



Location: _____

MR # _____
DOB: _____

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PATIENT'S SIGNATURE (IF SIGNATURE OTHER THAN PATIENT, LIST RELATIONSHIP)

DATE

WITNESS' SIGNATURE

DATE