



Psychiatry

MR #: \_\_\_\_\_

Name: \_\_\_\_\_

Northern California

**ADULT PERSONAL DATA SHEET**

IMPRINT AREA

Antioch     Martinez     Pleasanton     Walnut Creek

ENCOUNTER DATE		PROVIDER: FIRST NAME, LAST NAME	
NAME		MEDICAL RECORD #	
ADDRESS		CITY	ZIP
HOME PHONE		WORK PHONE	
AGE	SEX	BIRTHDATE	PLACE OF BIRTH
EMERGENCY CONTACT		PHONE	
REFERRED TO THIS CLINIC BY:		MILITARY SERVICE	
OCCUPATION		HOW LONG ON PRESENT JOB	
EMPLOYER		USUAL WORK HOURS	
HOW LONG HAVE YOU LIVED IN THIS AREA?		LAST SCHOOL GRADE COMPLETED	
CHECK ONE: <input type="checkbox"/> Married/Partnered <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
LIVING WITH SPOUSE/PARTNER: <input type="checkbox"/> Yes <input type="checkbox"/> No		NUMBER OF YEARS	
ETHNICITY		RELIGION	

Do you have a work-related problem?     Yes     No

Are you currently on:

a) Workers' Compensation?     Yes     No

b) SSI?     Yes     No

c) State Disability?     Yes     No

Do you want to initiate a Workers' Compensation or disability claim at your appointment?     Yes     No

**TYPE(S) OF HELP DESIRED:**

Medication Therapy     Counseling/Therapy     Substance Use/Abuse Treatment  
 Group Counseling     Family Counseling     Couples Counseling     Other: \_\_\_\_\_

1. Major reason(s) for seeking help at this time: \_\_\_\_\_

\_\_\_\_\_

2a. How long have you had these problems or symptoms? \_\_\_\_\_

\_\_\_\_\_

2b. How often do they occur? \_\_\_\_\_

\_\_\_\_\_

3. Why did you decide to seek help now? \_\_\_\_\_

\_\_\_\_\_

4. What have you tried? \_\_\_\_\_

\_\_\_\_\_

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**5. Past Psychiatric Treatment**

	Type (Individual/Family)?		By Whom?	Year?	Helpful? (Y/N)	
	Yes	No			Yes	No
<b>Counseling or Psychotherapy</b>			1.			
			2.			
			3.			
			4.			
			5.			
	Name of Medication?		By Whom?	Year?	Helpful? (Y/N)	
	Yes	No			Yes	No
<b>Psychiatric Medication(s)</b>			1.			
			2.			
			3.			
			4.			
			5.			
			6.			
			7.			
	Where?		Why?	Year?	Helpful? (Y/N)	
	Yes	No			Yes	No
<b>Psychiatric Hospital Admissions</b>			1.			
			2.			
			3.			
			4.			
			5.			
			6.			

**6. Check items below that apply to your current and past condition(s):**

	Current	Past		Current	Past		Current	Past
Headaches								
Dizziness			Restlessness			Hear voices others don't hear		
Stomach/bowel trouble			Decreased need for sleep			See things others don't see		
Health problems			Mood swings			Strange experiences		
Pain			Excess energy &/or feeling wired			Feel people plot against you		
Tremors or tics						Constant suspicion/distrust		
Drug &/or alcohol cravings			Confusion			Unusual thoughts		
Eating problems			Elated/euphoric mood			Someone physically harming you		
Binge eating			Excessive spending			Thoughts of physically harming someone else		
			Racing/overflow of thoughts			Violent/aggressive behavior		
Sleep problems			Irritable					
Weight loss			Impulsive behavior			Physical abuse		
Weight gain			Grandiose thoughts/plans			Sexual abuse		
Loss of appetite			Anger or explosiveness			Sexual problems		
Feeling apart from other						Relationship problems		
Low energy			Panic attacks					
Feeling worthless			Anxiety					

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6. continued . . .	Current	Past		Current	Past		Current	Past
Memory problems			Fears			Financial problems		
Thoughts of suicide			Nightmares			Conflict in family		
Planning suicide			Fears of losing self control					
Feeling depressed			Recurring unwanted thoughts/behaviors					
Crying a lot			Always worried					
Unable to have a good time			Concentration problems					

 7. Do you have any serious or chronic medical conditions (including past surgeries)  Yes  No  
 If yes, date(s) and details: \_\_\_\_\_

 8. Do you have any serious medical accidents or injuries, head injury, or seizure history?  Yes  No  
 If yes, date(s) and details: \_\_\_\_\_

 9. Are you currently taking any medications (include over-the-counter and herbal)?  Yes  No  
 If yes, please list: \_\_\_\_\_

 10. Have you had any allergic reactions to, or other problems with medications?  Yes  No  
 If yes, details: \_\_\_\_\_

**11. ALCOHOL AND OTHER DRUG USE:**

 A. Do you use alcohol?  Yes  No  
 How much per day/week? \_\_\_\_\_ Age when you started drinking? \_\_\_\_\_  
 Last drink taken (time and amount): \_\_\_\_\_

 B. Do you use other drugs?  Yes  No  
 What kind? \_\_\_\_\_  
 How much? \_\_\_\_\_  
 Age you started using? \_\_\_\_\_  
 Last drug use (time and amount): \_\_\_\_\_

 C. Do you feel you have a problem with:  
 Alcohol  Yes  No  
 Other drugs  Yes  No  
 If so, explain: \_\_\_\_\_

D. Previous treatment programs (list dates and locations, if possible): \_\_\_\_\_

 E. Has your drinking/drug use caused problems in the family or with your relationships?  Yes  No

 F. Caused problems on your job?  Yes  No

 G. Is it difficult for you to stop or control the amount you take?  Yes  No

 H. Have you ever been arrested for a D.U.I. (driving under the influence) or other drug related offense(s)?  Yes  No  
 If so, when? \_\_\_\_\_

 I. Have you ever used tobacco products?  Yes  No

What kind and how much? \_\_\_\_\_

When did you start? \_\_\_\_\_

When did you stop? \_\_\_\_\_

Did you use a program to stop? (please describe) \_\_\_\_\_

J. How many cups of caffeinated beverage(s) do you drink per day? (coffee, tea, colas, chocolate): \_\_\_\_\_

continued on next page



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12. Have you had any financial problems, legal difficulties/problems or previous imprisonment?     Yes     No

If yes, dates and details: \_\_\_\_\_

13. Have relatives/significant others had psychiatric symptoms or drug or alcohol problems?     Yes     No

Relative	Symptoms/Problems	Treatment	Psychiatric Medications	Psychiatric Hospitalizations

14. Have any family members had problems with criminal offenses, been in jail/prison?     Yes     No

If yes, who, why? \_\_\_\_\_

**15. FAMILY DATA**

Name	City Residence	Check (✓) if living with you	If living, age	If deceased age at, and year of death	Occupation	How do/did you get along
Spouse/Partner						
Children						
Father						
Stepfather						
Mother						
Stepmother						
Siblings/Step Siblings						
Others in household						

PATIENT SIGNATURE

DATE



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**CONFIDENTIALITY DISCLOSURE**

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

Kaiser Permanente's Mental Health and Chemical Dependency (MH/CD) Program is 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 chemical dependency 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, psychotherapy records of your MH/CD visits are kept separate from your outpatient medical record. Regardless of the type of visit, however, for your personal safety, your medication visits, the list of medications, laboratory results, a description of medication results, and prognosis are included in your medical record, either on paper or electronically.

**Coordination of Care**

At Kaiser Permanente MH/CD services staff are considered one department, the Department of Psychiatry. Therefore, any MH/CD information can be shared between Mental Health staff and Chemical Dependency staff within the department without your written permission. However, the regulations pertaining to disclosing information outside the Department of Psychiatry are different for mental health patient information than for chemical dependency patient information.

Patients Receiving Only Mental Health Care: For mental health care, your permission is not required to coordinate your care with other providers within Kaiser Permanente, such as your primary care physician. Mental Health diagnoses and appointment dates are available to your other Kaiser Permanente treating providers on a need-to-know basis. However, ordinarily we will discuss with you any necessary sharing of other mental health 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.

Patients Receiving Chemical Dependency Care: For chemical dependency care (which would include mental health care that is part of your chemical dependency care), your written authorization is normally required before any information about chemical dependency treatment can be disclosed to anyone outside the Department of Psychiatry. For your safety and effective coordination of your health care, we strongly believe it is important for us to share information about your chemical dependency treatment with your other Kaiser Permanente treating providers. In order for us to do that, you must sign a written authorization to allow us to share your chemical dependency patient information with them.

**Exceptions to Confidentiality Rules**

Sometimes the law authorizes us to disclose information about you without your permission, such as disclosures:

- in medical and psychiatric emergencies in which the information is essential to an individual's safety
- to warn potential victims of violent acts
- to qualified personnel for audit, program evaluation, or research; for example, patient surveys
- for reporting of suspected child abuse or neglect
- to report the commission of crimes on our premises or against our program personnel
- in response to court orders that comply with the standards for the type of record covered by the order
- in reports to the Department of Motor Vehicles due to lapses of consciousness as required by law

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



KAISER PERMANENTE®

Psychiatry

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Name: \_\_\_\_\_

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## CONSENT TO TREATMENT

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## 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