



Psychiatry

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

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

Northern California

**ADOLESCENT QUESTIONNAIRE (12 and Above)**

IMPRINT AREA

Antioch     Martinez     Pleasanton     Walnut Creek

ENCOUNTER DATE

PROVIDER: FIRST NAME, LAST NAME

NAME	AGE	
ADDRESS (STREET)	CITY, ZIP CODE	PHONE NUMBER
MEDICAL RECORD #	ETHNICITY/COUNTRY OF ORIGIN	RELIGION
SCHOOL	GRADE	JOB

Whose idea was it for you to be seen here today?     Mine     Parent(s)     Other  
 If someone other than you, are you okay with this idea?     No     Yes     Not sure

For what problems are you seeking counseling/psychiatric help? \_\_\_\_\_

Have you ever seen a counselor in the past?     No     Yes

If so, whom? \_\_\_\_\_

When did you see the counselor? \_\_\_\_\_

Why did you see the counselor? \_\_\_\_\_

How was it helpful? \_\_\_\_\_

**FAMILY HISTORY:**

With whom do you live? (Check the most appropriate choice)

Both parents     Mother     Father     Other family     Someone else, Specify: \_\_\_\_\_

Present amount of contact with parents:

Father (if deceased, give date \_\_\_\_\_)

Daily     Once per year or less  
 Weekly     Never  
 Monthly

Mother (if deceased, give date \_\_\_\_\_)

Daily     Once per year or less  
 Weekly     Never  
 Monthly

**Describe your family:**

	Mother	Father	Stepmother	Stepfather	Brother	Sister	Other
Likes me							
Kind							
Pleasant							
Understanding							
Easygoing							
Rarely home							
Strict							
Mean							
Harsh							
Critical							
Negative							
Angry							
Uses drugs							
Uses alcohol							
Verbally abusive							
Physically abusive							

**Kind of punishment – indicate who:**

	Mother	Father	Stepmother	Stepfather
Sends you to your room				
Takes away privileges				
Restricts or grounds you				
Spanks/hits				
Other, Please explain:				



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**MEDICAL HISTORY:**

Do you have or have you ever had any significant medical problems or been hospitalized?  No  Yes

If so, please list: \_\_\_\_\_

Are you on any medications? (Include birth control pills)  No  Yes

If so, please list: \_\_\_\_\_

Have you been or are you now sexually active?  No  Yes

Do you practice safe sex?  No  Yes

What is your sexual preference/orientation? \_\_\_\_\_

For females: Have you started your period?  No  Yes At what age? \_\_\_\_\_

Are you pregnant?  No  Yes

Have you ever been pregnant?  No  Yes

Have you ever drunk alcohol?  No  Yes How often?  Daily  Weekly  Rarely

Do you smoke or use tobacco?  No  Yes

Do you use drugs?  No  Yes If so, what kind? \_\_\_\_\_

	NOW	PAST		NOW	PAST
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	LSD	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant	<input type="checkbox"/>	<input type="checkbox"/>
Crank	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Please specify:	_____	

Does your habit hurt your relationship with others?  No  Yes Does it interfere with your performance at school?  No  Yes

How long ago did your habit begin? \_\_\_\_\_

Do you think it's a problem?  No  Yes Would you like to stop your habit?  No  Yes

**LEGAL HISTORY:**

Have you ever had police/court involvement? (Check one answer)

No, never  Yes, within the past month  Yes, within the past 6 months  Yes, within the past year  Yes, over 1 year ago

Do you see a social worker or probation officer on a regular basis?  No  Yes

If so, name, address and phone number: \_\_\_\_\_

**SYMPTOMS: Have you had any of the following experiences or problems, now or in the past?**

	Current	Past		Current	Past		Current	Past
Restless and unable to sit still			Hurt animals			Slurred speech		
Act without thinking			Sneak out at night			Eat little or fast to lose weight		
Difficulty paying attention			Hurt people			Vomit food intentionally		
Low motivation			Sexual problems			Gorge food		
Short attention span			Problems with the law			Hearing voices or seeing things that aren't there		
Easily frustrated			Fire-setting			Headache		
Easily distracted			Been arrested, in jail or on probation					
Daydream or fantasize a lot						Sadness, crying and/or depression		
Temper outbursts			Nervous/can't relax			Hard to make decisions		
Uncooperative			Worry more than others			Irritable/angry		
Back talk			Very anxious			Withdrawn from others		
Hard to admit mistakes			Worry a lot about past behavior			Trouble concentrating		
Argue a lot			Fearful			Trouble going to sleep		
Enjoy "bugging" people			Worry a lot about the future			Memory problems		
Swear or use obscene language			Unusual fears or phobias			Restless sleep, wake up frequently		

continued on next page

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SYMPTOMS (continued)						
	Current	Past	Current	Past	Current	Past
Easily annoyed by others			Panic		Nothing fun anymore	
			Overly concerned about germs, safety, and/or health issues		Wake up very early and can't go back to sleep	
Use alcohol/drugs			Repeat an act over and over that is not necessary to do (e.g., washing, checking locks, counting, lining things up)		Low self-esteem	
Smoke cigarettes					Sleep too much	
Rebellious attitude or behavior			Seem confused a lot		Feeling tired and fatigued	
Damaged property			Can't control body movement		Nightmares, night fears	
Want to run away from home			Not knowing where you are		Weight gain or weight loss	
Stolen things			Feeling odd or different than other people		Have made suicide attempts in the past	
Have run away from home			Blurred or double vision			

**Have you had any of the following experiences or problems, now or in the past?**

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
I feel it is too painful to keep on living				
I feel my family would be better off if I were dead				
I think about suicide				
I have thought of how to kill myself				
In order to punish others, I think of suicide				

**Check the boxes that describe your relationships with others:**

- |   |   |
|---|---|
| <input type="checkbox"/> Prefer to be alone   | <input type="checkbox"/> I have a lot of friends                                |
| <input type="checkbox"/> Alone a lot, but dislike this and feel lonely                    | <input type="checkbox"/> I go out with friends. Where? _____                    |
| <input type="checkbox"/> Problem getting along with others                                | <input type="checkbox"/> I have a steady boyfriend/girlfriend. Their age? _____ |
| <input type="checkbox"/> Shy  | <input type="checkbox"/> Conflict with my parents or step-parents               |
| <input type="checkbox"/> Difficulty getting along with my brothers and sisters            | <input type="checkbox"/> Being physically or sexually abused                    |
| <input type="checkbox"/> Family member drinks too much                                    | <input type="checkbox"/> Being neglected  |
| <input type="checkbox"/> Family member uses drugs   | <input type="checkbox"/> Getting picked on a lot by peers? _____                |
| <input type="checkbox"/> Family member, relative, or friend tried to kill himself/herself | By family member? _____   |
| <input type="checkbox"/> I have a best friend   |   |

**I have had these problems at school:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Difficulties with classmates    | <input type="checkbox"/> Poor grades                                 | <input type="checkbox"/> Been expelled (# of times _____) |
| <input type="checkbox"/> Not having friends at school    | <input type="checkbox"/> Learning problem                            | <input type="checkbox"/> Getting into fights at school    |
| <input type="checkbox"/> Not getting along with teachers | <input type="checkbox"/> Have been on detention (or Saturday school) |   |
| <input type="checkbox"/> Cutting school or classes       | <input type="checkbox"/> Been suspended (# of times _____)           |   |

**Additional Comments:** \_\_\_\_\_

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PATIENT'S SIGNATURE

DATE

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**Teen Mood Self-Report**

SCORE

**CES-D Instructions:** Below is a list of some of the ways you might have felt or acted. Please indicate how often you have felt this way during the past week by checking the appropriate space. Check only one box per question.

**During the past week:**

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1–2 days)	Occasionally or a moderate amount of time (3–4) days	All of the time (5–7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt like I could not shake off the blues even with help from my family or friends.				
4. I felt like I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt people disliked me.				
20. I could not get "going."				

**Self-harm questions:** Please check the answer that is true for you.

Have you had any of the following thoughts or feelings, now or in the past?

	Never or not at all	Sometimes	Often	All the time
1. I feel it is too painful to keep living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I feel my family would be better off if I were dead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I think about suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have thought about how to kill myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In order to punish others, I think of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



KAISER PERMANENTE®

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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

IMPRINT AREA

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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