



Psychiatry

MR #: _____

Name: _____

Northern California

CHILD, ADOLESCENT, AND FAMILY DATA

IMPRINT AREA

Antioch Martinez Pleasanton Walnut Creek

ENCOUNTER DATE

PROVIDER: FIRST NAME, LAST NAME

To be completed by parent or guardian

CHILD'S NAME		CHILD'S MEDICAL RECORD #	
PEDIATRICIAN	CHILD'S BIRTHDAY	ETHNICITY/COUNTRY OF ORIGIN	CHILD'S AGE
CHILD'S ADDRESS (STREET)		(CITY, ZIP CODE)	PHONE (HOME)
NAME OF PERSON COMPLETING FORM		RELATIONSHIP	RELIGION
SCHOOL (NAME & ADDRESS)		SCHOOL DISTRICT	SCHOOL GRADE
CHECK ONE: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried		IF DIVORCED, WHO HAS LEGAL CUSTODY?	
MOTHER'S NAME	MOTHER'S MR#	HOME PHONE	WORK PHONE
FATHER'S NAME	FATHER'S MR#	HOME PHONE	WORK PHONE
EMERGENCY CONTACT NAME			DAY TIME PHONE
GUARDIAN'S NAME, IF DIFFERENT			DAY TIME PHONE

Consent for Treatment and Inside Information Release

I am legal guardian of _____ with full legal authority to consent to treatment, and I hereby consent to mental health evaluation and/or treatment of him/her by personnel of the Department of Psychiatry, The Permanente Medical Group, Inc., Northern California:

NAME OF CHILD

SIGNATURE OF PARENT OR GUARDIAN

DATE

SIGNATURE OF ADOLESCENT PATIENT (12 AND OLDER) IF APPLICABLE

DATE

Statement of Confidentiality

All information contained in this form is subject to laws regarding the therapist-client relationship. By law we are required to report:

1. Any suspected child abuse.
2. Threats of violence made against any person.

Psychiatric records are kept in the Department of Psychiatry and can be released only by legal authorization. Further, some verbal or brief written report is usually submitted to the child's pediatrician, and a brief psychiatric note is often placed in the MEDICAL chart for pediatric cases. If medication is prescribed, a note **MUST ALSO** be placed in the outpatient MEDICAL chart.

If MEDICAL information is copied for authorized release, PSYCHIATRIC information in the MEDICAL chart is first removed.



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CHILD'S MAIN PROBLEM/MAJOR REASONS FOR SEEKING HELP NOW: _____

DESCRIBE ANY OTHER BEHAVIORAL OR EMOTIONAL PROBLEMS: _____

DESCRIBE THE IMPACT ON THE FAMILY OF YOUR CURRENT CONCERNS: _____

DESCRIBE YOUR CHILD'S STRENGTHS AND UNIQUE QUALITIES: _____

PREVIOUS COUNSELING OR TREATMENT? NO YES

INPATIENT OUTPATIENT OTHER _____

If yes, briefly describe condition(s) needing help, who was therapist or counselor, comments regarding outcome, and dates of treatment:

WHAT HAVE YOU TRIED OTHER THAN COUNSELING AND TREATMENT? _____



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HAS THERE BEEN ANY ABUSE OF THE CHILD?

PHYSICAL NO YES

EMOTIONAL NO YES

SEXUAL NO YES

NEGLECT NO YES

If yes, please describe briefly: _____

IS THERE A LEGAL ACTION PENDING? If yes, describe it. NO YES

NOTE: Service which is court ordered, a condition of probation, parole, or for legal or custody evaluation, may be excluded by Health Plan contract provisions.

IS THERE A HISTORY OF LEGAL ACTION? If yes, describe it. NO YES

CUSTODY NOW PAST

CHILD PROTECTION NOW PAST

VISITATION NOW PAST

ADOPTION NOW PAST

PROBATION NOW PAST

BEHAVIOR CHECKLIST: Please check any of the following behaviors that concern you.

	Current	Past		Current	Past		Current	Past
Sadness, crying, depression			Temper outbursts			Worries more than others		
Loss of enjoyment of usual activities			Irritable, angry			Unusual fears or phobias		
Expressing a wish to die			Argues a lot			Panics		
Bedtime fears, won't sleep			Disobeys			Anxious, nervous		
Has threatened or attempted suicide			Does things that annoy other people			Repeats an act over and over that is unnecessary (e.g. washing, checking doors, counting, lining things up)		
Sleepwalking			Blames others for own mistakes			Is overly concerned about things (e.g. germs, safety, or their health)		
Withdrawn			Easily annoyed by others			Has rituals, habits, superstitions		
Nightmares, night terrors			Swears and uses obscene language			Twitches or unusual movements		
Low self-esteem						Eats little or fasts to lose weight		
Waking up very early and unable to go back to sleep			Wanting to run away			Gorges food		
Tiredness, fatigue			Sneaks out at night			Injures self		
Restless sleep, wakes up frequently			Stealing			Hallucinations (hears or sees things that aren't there)		
Poor appetite			Lying			Vomits intentionally		
Under or overweight			Hurts animals			Strange or unusual behavior		
Trouble going to sleep			Hurts people			Disorientation (confused about the time, who he/she is and where he/she is)		
Sleeps too much			Destroys property			Bedwetting/daytime wetting		
			Drug use			Soiling (pooping) in pants		

continued on next page

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BEHAVIOR CHECKLIST (continued)

	Current	Past		Current	Past		Current	Past
Over activity			Alcohol use					
Frequently acts without thinking			Cigarette use					
Doesn't finish things			Sexual problems					
Disruptive			Problems with authority					
Short attention span			Problems with the law					
Daydreams, fantasizes			Has been arrested and/or on probation					
Easily distracted								
Low motivation level								

Check items that describe your child's relationship development (present or past):

- | | | |
|---|--|---|
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Is picked on a lot | <input type="checkbox"/> Plays with younger kids |
| <input type="checkbox"/> Is alone a lot, but dislikes this and feels lonely | <input type="checkbox"/> Poor relationship with peers | <input type="checkbox"/> Plays with older kids |
| <input type="checkbox"/> Is shy | <input type="checkbox"/> Poor relationship with teacher(s) | <input type="checkbox"/> Fights with others |
| <input type="checkbox"/> Has few friends | <input type="checkbox"/> Is oversensitive | <input type="checkbox"/> Has difficulty getting along with brothers and sisters |
| <input type="checkbox"/> Has many friends | <input type="checkbox"/> Is demanding and bossy | <input type="checkbox"/> Conflict with parents or step-parents |
| <input type="checkbox"/> Plays with "problem kids" | <input type="checkbox"/> Bullies others | |
| | <input type="checkbox"/> Teases a lot | |

Forms of discipline used:

- | | | |
|---|--|---|
| <input type="checkbox"/> Time-out | <input type="checkbox"/> Grounding | <input type="checkbox"/> Extra chores |
| <input type="checkbox"/> Loss of privileges | <input type="checkbox"/> Physical punishment | <input type="checkbox"/> Rewards/incentives |
| <input type="checkbox"/> Other: _____ | | |

School
Check any area of concern:

- | | | |
|--|--|---|
| <input type="checkbox"/> Dislikes school | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Repeated a grade |
| <input type="checkbox"/> Works hard, but does not do well | <input type="checkbox"/> Expulsions, how many? _____ | <input type="checkbox"/> Discipline referrals/detention |
| <input type="checkbox"/> Unmotivated, refuses to complete work | <input type="checkbox"/> Missed many school days | <input type="checkbox"/> Suspensions, how many? _____ |

School environment:

- | | | |
|---|--|--|
| <input type="checkbox"/> Resource classes/special education | <input type="checkbox"/> Speech therapy | <input type="checkbox"/> Home study |
| <input type="checkbox"/> Gifted program | <input type="checkbox"/> Continuation school | <input type="checkbox"/> Independent study |

Family stresses
Now or previously have there been:

- | | | |
|---|--|--|
| <input type="checkbox"/> Marital problems | <input type="checkbox"/> Family stresses | <input type="checkbox"/> Death of a pet |
| <input type="checkbox"/> Marital separation | <input type="checkbox"/> Housing problems | <input type="checkbox"/> Family illness |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Legal stresses | Number of days missed from work _____ |
| <input type="checkbox"/> Custody disputes | <input type="checkbox"/> Death of a friend | <input type="checkbox"/> Job loss |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Death of a relative | <input type="checkbox"/> Parents drugs and alcohol |

 Other: _____



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DEVELOPMENTAL HISTORY:

DURING PREGNANCY DID YOU?

DRINK SMOKE DRUGS ACCIDENT ILLNESS

DID YOU HAVE ANY PROBLEMS WITH PREGNANCY, LABOR, OR DELIVERY? NO YES

If yes, please describe: _____

Please indicate at what age your child:

_____ Held head up	_____ Walked alone	_____ Fed self	_____ Was toilet trained
_____ Turned over	_____ Crawled	_____ Used single words	_____ Slept through the night
_____ Sat up	_____ Was weaned	_____ Used sentences	_____ Dressed self

My child as a baby (check all that apply):

<input type="checkbox"/> Ate well	<input type="checkbox"/> Was easy to soothe	<input type="checkbox"/> Was clumsy
<input type="checkbox"/> Was colicky	<input type="checkbox"/> Was easy to regulate (sleep, eat)	<input type="checkbox"/> Had dare-devil behavior
<input type="checkbox"/> Had head banging	<input type="checkbox"/> Wanted to be left alone	<input type="checkbox"/> Was adaptable to transitions
<input type="checkbox"/> Had rocking behavior	<input type="checkbox"/> Was more interested in things than people	

MEDICAL HISTORY:

Indicate if your child had/has any of the following:

	Yes	No	Age	Explain
Serious infection				
Convulsions				
Head injuries				
Other injuries				
Operations				
Ear infections				
Any poisonings				
Allergies				
Asthma				
Alcoholism				
Drug use				
Sexual problems				

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FAMILY INFORMATION (continued)

Indicate if any family members or relatives have any of the following:	Mother		Father		Brother		Sister		Other Relative (specify)	
	NOW	PAST (When)	NOW	PAST (When)	NOW	PAST (When)	NOW	PAST (When)	NOW	PAST (When)
Problems with attention, activity, and impulse control as a child										
Learning disabilities										
Did not graduate from high school										
Alcohol abuse										
Drug use										
Problems with aggressive behavior as a child or adult										
Antisocial behavior (jail arrests, legal problems, probation)										
Abuse victim										
Abusive to others										
Depression										
Nervous disorders										
Mental retardation										
Serious illness or operations										
Physical handicaps										
Tics or unusual movements										
Other mental problems										

WHAT ARE YOUR FAMILY SUPPORTS (i.e., church, friends, clubs)? _____

WHAT ARE YOUR FAMILY STRENGTHS? _____

Additional Comments: _____

PEDIATRIC SYMPTOM CHECKLIST

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CHILD'S NAME

DATE OF BIRTH

TODAY'S DATE

FILLED OUT BY

Please check box under the heading that best fits your child:

Never

Sometimes

Often

- | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|
| 1 | Complains of aches/pains | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Spends more time alone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Tires easily, little energy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Fidgety, unable to sit still | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Has trouble with a teacher | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | Less interested in school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 | Acts as if driven by a motor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | Daydreams too much | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 | Distracted easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 | Is afraid of new situations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 | Feels sad, unhappy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 | Is irritable, angry | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 | Feels hopeless | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 | Has trouble concentrating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 | Less interest in friends | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16 | Fights with others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17 | Absent from school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18 | School grades dropping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19 | Is down on him or herself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 | Visits doctor with doctor finding nothing wrong | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21 | Has trouble sleeping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22 | Worries a lot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23 | Wants to be with you more than before | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24 | Feels he or she is bad | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25 | Takes unnecessary risks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26 | Gets hurt frequently | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27 | Seems to be having less fun | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28 | Acts younger than children his or her age | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29 | Does not listen to rules | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30 | Does not show feelings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31 | Does not understand other people's feelings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32 | Teases others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33 | Blames others for his or her troubles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 34 | Takes things that do not belong to him or her | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 35 | Refuses to share | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other comments:



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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