



Chemical Dependency

Do not release patient information without specific authorization per 42 CFR

MR #: _____

Name: _____

Northern California

**CDRP/CDS ADOLESCENT PROGRAM
ADOLESCENT'S DATA SHEET**

IMPRINT AREA

Antioch Martinez Pleasanton Walnut Creek

ENCOUNTER DATE

PROVIDER: FIRST NAME, LAST NAME

NAME _____

ADDRESS _____

PHONE (HOME)

PHONE (WORK)

PAGER/CELL

MOTHER'S NAME

PHONE (HOME)

PHONE (WORK)

FATHER'S NAME

PHONE (HOME)

PHONE (WORK)

Please answer the following questions as accurately and completely as possible.

1. In your own words, what events in your life led you to coming here today? _____

2. Please rank your problems in the following areas on a scale from 1-10 (1 = no problem, 10 = major problems). You may use the same number for more than one area:

_____ Parents _____ School _____ Friends _____ Partying

_____ Depression _____ Gangs _____ Sex _____ Legal

_____ Anger/violence _____ Suicidal thoughts _____ Eating or not eating

_____ Other (please state the nature of the problem): _____

3. What is your gender? Male Female Age: _____ Date of birth: _____

4. What is your race or ethnicity:

African American/Black Caucasian/White Asian Native American Indian
 Latino/Hispanic Pacific Islander Biracial Other (describe): _____

5. Which best describes you now?

Student in school full time Student, currently suspended Not attending school; not working
 Student currently in home study Student, currently expelled Other: _____
 Student in Adult School Not attending school; working full time
 Student in Continuing School Not attending school; working part time

6. What school are you now attending (or last enrolled)? _____

7. What grade are you in? _____



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8. If you work, what best describes your current job type? (If you do not work, skip to question 11)

- Helper/laborer/delivery person Machine and/or vehicle operator Service worker/babysitter
- Clerical worker Craftsman/repairman Salesperson
- Cashier Other (please describe): _____

9. What city/town do you work in? (Please provide ZIP code) _____

10. If working, what is your weekly income?

- Under \$50 per week \$100–\$200 per week \$300 plus
- \$50–\$100 per week \$200–\$300 per week No income

11. What is your present religion? (Check one answer)

- Protestant Jewish Christian None
- Catholic Moslem Other (please describe): _____

12. What is your sexual orientation?

- Heterosexual Gay Lesbian Bisexual

13. Are you currently sexually active?

- Yes No

14. Who referred you to this program? (Check all that apply)

- Self Alcoholics Anonymous/Narcotics Anonymous/Cocaine Anonymous
- Emergency Room Medical Doctor, name: _____
- Parents Mental Health Therapist, name: _____
- School Court—P.O., name: _____
- Friend Other (please describe): _____

15. What has led you to seek treatment for using alcohol or other drugs now? (Check all that apply)

- Problems at school Health problems Personal or emotional concerns
- Legal difficulties (e.g., DUI) Family or relationship problems Pregnancy
- Parents Other (please describe): _____

16. Do you have any ongoing medical problems? (Check all that apply)

- Heart problems Ulcer/stomach Eating Problems No ongoing medical problems
- Lung/respiratory disorder Other (please describe): _____

17. In the last month, have you stopped doing exercise/activity due to respiratory problems, lack of energy, constant colds, or infection?

- Yes No



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18. Have you had any medical problems or accidents associated with alcohol and/or other drugs?

No Yes What? _____

19. Are you currently taking ANY prescription or over-the-counter medications?

No Yes Which ones? _____

20. Are you allergic to ANY medications as far as you know?

No Yes Which ones? _____

21. When was the last time you drank/used? Date: _____ Time: _____

22. What did you use? _____

23. How much did you use? _____

The following questions are about your use of alcohol and other drugs IN THE PAST 6 MONTHS. Please mark the column indicating your average use of each of the substances listed below IN THE PAST 6 MONTHS.

SUBSTANCES	DAILY (a)	4-6 DAYS PER WEEK (b)	1-3 DAYS PER WEEK (c)	LESS THAN WEEKLY (d)	LESS THAN ONCE PER MONTH (e)	LAST USED MORE THAN 6 MONTHS AGO (f)	NEVER USED
24. Nicotine/cigarettes							
25. Alcohol, any at all							
26. Marijuana or hashish							
27. Stimulants, amphetamines, or crank							
28. Cocaine or crack							
29. Inhalants (chemo)							
30. Hallucinogens/mushrooms (LSD, PCP, ecstasy, etc.)							
31. Prescribed pain killers (Demerol, Talwin, Darvon, Vicodin, Codeine, etc.)							
32. Tranquilizers (Valium, Librium, Xanax, etc.)							
33. Sedatives, barbiturates, or hypnotics (sleeping pills)							
34. Heroin or methadone							
35. Other substances: _____							



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The following questions relate ONLY to your use of ALCOHOL (EXCLUDING OTHER DRUGS AND TOBACCO). If you do not use alcohol, please skip to question #47.

36. Have you ever had the "shakes" when sobering up (hands tremble, shake inside)?

- No Sometimes Almost every time I drink

37. Do you get physically sick (e.g., vomit, stomach cramps) as a result of drinking?

- No Sometimes Almost every time I drink

38. Have you had the "DTs" (delirium tremens), that is, seen, felt, or heard things not really there, felt anxious, restless, and overexcited?

- No Once Often

39. Have you had blackouts ("loss of memory" without passing out) as a result of drinking?

- No, never (skip to question #41) Sometimes

40. With respect to blackouts (loss of memory) have you:

- Had blackouts that last for several hours Had blackouts that last less than an hour
 Had blackouts that last for a day or more

41. Have you ever had a convulsion (fit) following a period of drinking?

- No Once Several times

42. As a result of drinking, have you "heard things" that were not really there?

- No Once or twice Several times

43. Do you gulp drinks (drink quickly)?

- No Yes

44. After taking one or two drinks, have you ever not been able to stop?

- No Yes

45. How often have you had to give up important social, school-related, recreational, or family activities because of your use of alcohol?

- Often Sometimes Rarely Never

46. How often did you continue to use alcohol even though your use caused family, school, emotional, or physical problems for you?

- Often Sometimes Rarely Never



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The following questions relate ONLY to your use of DRUGS and/or OTHER SUBSTANCES (EXCLUDING ALCOHOL AND TOBACCO) over the past 6 months. If you do not use drugs or other substances, please skip to question #55.

47. Have you ever tried to cut down or control your use of drugs?

No Yes; were you able to cut down or control your use? No Yes, partially Yes, completely

48. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

No Yes I have not stopped taking drugs

49. How often have you had to give up important social, school-related, recreational, or family activities because of your use of drugs?

Often Sometimes Rarely Never

50. How often did you continue to use drugs even though your use caused family, school, emotional, or physical problems for you?

Often Sometimes Rarely Never

51. How often have you had "blackouts" or "flashbacks" as a result of drug use?

Often Sometimes Rarely Never

52. How often did you find that it took more drugs to get high?

Often Sometimes Rarely Never

53. How often did you find yourself getting less high on the same amount of drugs?

Often Sometimes Rarely Never

54. Have you ever used IV needles to inject drugs?

Yes No

55. Have you taken alcohol or other drugs to avoid or relieve withdrawal symptoms?

Often Sometimes Rarely Never

56. Have you had any medical problems that you think were related to alcohol or other drug use (e.g., memory loss, convulsions, bleeding, etc.)?

No Yes Which ones? _____

57. Have you ever had hepatitis?

No Yes: hepatitis A hepatitis B hepatitis C

58. At what age did you start using drugs and/or other substances? _____ years

59. Is there a person or any group of people you spend much time with who might make it hard for you to cut back on using alcohol or other drugs?

No Yes (check all that apply): Family member Friend Coworker Other: _____



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67. About what things do you and your parent(s) argue?

- Friends Grades Alcohol/drugs
- Curfew Chores Other: _____

68. Have you ever been involved in fights? No Yes

69. Have you been involved in gang activity? No Yes Currently

In the last month, how much:	Not at all	A little	Some of the time	Most of the time	All the time
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70. Have you felt down or sad? 0 1 2 3 4

71. Had less of an interest in things? 0 1 2 3 4

72. Had a weight change? 0 1 2 3 4

Loss Gain # pounds: _____

73. Have your sleeping habits changed? 0 1 2 3 4

- Up all night, sleep all day Sleeping a lot
- Difficulty waking up Difficulty falling asleep

74. Have you felt a loss of energy? 0 1 2 3 4

75. Have you had difficulty concentrating? 0 1 2 3 4

76. Feelings of worthlessness? 0 1 2 3 4

77. Lost your ability to control your temper? 0 1 2 3 4

78. Have you had thoughts of death/suicide? 0 1 2 3 4

79. Is there anything else you would like to tell us about? _____

PATIENT'S SIGNATURE

DATE



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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



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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