



Chemical Dependency

Do not release patient information without specific authorization per 42 CFR

MR #: _____

Name: _____

Northern California

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

IMPRINT AREA

Antioch Martinez Pleasanton Walnut Creek

ENCOUNTER DATE

PROVIDER: FIRST NAME, LAST NAME

Please fill out the following as completely as possible. This will make it unnecessary to ask you routine questions and save time for more important discussions.

NAME _____ AGE _____ MEDICAL RECORD NUMBER _____

ADDRESS _____

If necessary, where and when can you be telephoned during the day?

RESIDENCE _____ BUSINESS _____ OTHER _____

OCCUPATION _____ HOW LONG _____ HOW LONG ON PRESENT JOB _____

EMPLOYED BY _____

BIRTH PLACE _____ RELIGION _____ MILITARY SERVICE _____

HOW LONG HAVE YOU LIVED IN THIS AREA? _____ LAST SCHOOL GRADE COMPLETED _____

MARITAL STATUS (CHECK ONE)

Single Separated Divorced Widowed Married Living with partner

IF MARRIED OR LIVING WITH PARTNER, HOW LONG? _____

If married more than once, list dates of marriages and whether each marriage terminated by divorce or death or annulment:

FIRST _____ TERMINATED BY _____

_____ to _____

SECOND _____ TERMINATED BY _____

_____ to _____

THIRD _____ TERMINATED BY _____

_____ to _____

1. What are some of the problems you have been concerned about with your child? _____

2. When did you start to have these concerns? _____

3. When and how did you learn of your child's drug and/or alcohol use? _____



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4. What have you tried to solve this problem so far? _____

5. Do you have any close friend(s) or relative(s) that you can discuss personal problems/feelings with? If yes, whom? _____

6. Please list any counseling, therapy, or hospitalization you may have had in the past.

YEAR	THERAPIST	LOCATION	LENGTH OF TREATMENT	TYPE OF TREATMENT	RESULTS

7. Have you experienced any of these conditions in the past year?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Always worried | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Easing problem | <input type="checkbox"/> Ready to explode | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Stomach/bowel trouble | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Relationship problems w/live-in partner |
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Tense/irritable | <input type="checkbox"/> Strange experiences | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Unusual thoughts | <input type="checkbox"/> Depression | <input type="checkbox"/> Unable to work well |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Fear things I shouldn't | <input type="checkbox"/> Drink excessively |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Fear of losing control | <input type="checkbox"/> Conflict within family | <input type="checkbox"/> Excessive use of drug(s) |
| <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Can't make friends | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Can't keep friends | <input type="checkbox"/> Not able to exercise |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Feel apart from people | <input type="checkbox"/> Other: _____ |

8. What medication(s) have you used during the last year? (Please include over-the-counter and prescription medications)

Name of Medication	For what condition is this medication prescribed?	How long have you been taking this medication?



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9. What serious medical problems, surgery, or accidents have happened to you? _____

10. Have you had any legal difficulties? _____

11. Developmental history of your child:

a. Were there any complications during pregnancy or delivery? Yes No If yes, what? _____

b. Did your child have any medical problems in the first two years? Yes No If yes, what? _____

Did these require hospitalization? Yes No If yes, how long? _____

c. At what age did your child walk? _____ Talk? _____ Become toilet trained? _____ Start school? _____

d. How did your child get along with peers in school? _____

12. Have you seen any unusual behavior in your child? Yes No If yes, what behaviors? _____

13. How does your child get along with his/her siblings? _____

14. How has your relationship changed with your child? _____

15. Is there anything else about your child's history that would be helpful for us to know? _____



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NAME	CHECK IF LIVING WITH YOU	CITY OF RESIDENCY	AGE	IF DECEASED, AGE & YEAR OF DEATH	MARITAL STATUS	OCCUPATION	HOW DO YOU (DID YOU) GET ALONG?
SPOUSE							
CHILDREN							
OTHERS LIVING IN HOUSEHOLD NOW							
FATHER							
MOTHER							
STEPPARENTS							
SISTERS AND BROTHERS (IN ORDER OF BIRTH)							

Which relatives have (or had) emotional difficulties or psychiatric illness, including alcoholism or drug problems?

RELATIVE	DIFFICULTY (PLEASE DESCRIBE)



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A CHECKLIST FOR TEENAGE BEHAVIOR

Before you start, read this first

This checklist contains four separate lists of behaviors that you may have noticed in your teen. Many of the listed behaviors often seem to be "normal" teenage behaviors. That is why it can be extremely difficult for parents to tell whether their child is just going through a "typical" teenage phase, may have a psychological problem, or may have become involved with drugs and/or alcohol. First, go down each of the four lists, checking the behaviors that apply. Then, after you have completed each list, we will use it in assessing your teenager.

Checklist One:

- Has your child become secretive?
- Has your child changed friends?
- Has your child changed in dress or appearance?
- Has your child become increasingly isolated, preferring to spend time alone?
- Have your child's school grades declined?
- Has your child dropped out of sports or other activities?
- Has your child been fired from work?
- Does your child stay out at night past your curfew?
- Have you ever noticed your child using excessive amounts of eye drops, gum, breath mints, or perfume?
- Have you ever been suspicious of your child's overall behavior, though you could find no evidence that anything was wrong?
- Has it become more difficult to get your child to participate in family activities?
- Has it become more difficult to get your child to do household chores?
- Has your child become more argumentative and uncooperative?

Total Checks from List One: _____

Checklist Two:

- Does your child seem depressed?
- Does your child seem to require extra sleep?
- Has your child become rebellious and defiant?
- Is your child "skipping" classes?
- Has your child been suspended from school or been ordered to in-school suspension?
- Does your child seem withdrawn from the family?
- Has your child started to smoke?
- Does your child spend long periods of time in the bathroom?
- Has your child become physically or verbally abusive to parents or other members of the family?
- Do you (or your child) receive "mysterious" phone calls at all hours?
- Has your child come home drunk?
- Has your child ever been caught stealing from family, relatives, or friends?
- Does your child avoid parental contact upon arrival at home?
- Does your child laugh excessively for no apparent reason?

Total Checks from List Two: _____



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Checklist Three:

- Have you ever found suspicious items (drug paraphernalia) around your home, in your child's room, or in your child's car?
- Have valuables been "disappearing" from your home?
- Have prescriptions or other medicines disappeared from your medicine cabinet?
- If you drink alcohol, have you noticed diluted contents or bottles disappearing from your liquor cabinet?
- Does your child ever seem to be possessing large amounts of money?
- Has your child ever been arrested due to alcohol or drug related events?
- Have you ever noticed that your child's eyes were bloodshot or pupils dilated?
- Has your child ever been arrested for vandalism, shoplifting, breaking and entering, or burglary?
- Does your child openly admit to using alcohol, marijuana, or other drugs?
- Does your child have persistent and chronic colds or respiratory congestion?
- Has your child ever threatened or attempted suicide?
- Has your child been expelled from or quit school?

Total Checks from List Three: _____

Checklist Four:

- Do you and your spouse frequently disagree or argue about your child's behavior?
- Do you often worry about your child's problems?
- Have you ever tried to cover up or make excuses for your child's behavior instead of discussing the situation with your friends, relatives, or school personnel?
- Do you feel frustrated because no matter how hard you try, nothing seems to change your child's behavior?
- Do you feel relieved when your child leaves the house?
- Do you feel anger, or a general dislike for your child?
- Are you afraid that you may have become a failure as a parent?
- Have you tried to change your behavior in the hopes that it would cause a change in your child's behavior?
- Do you give money to your child without your spouse's knowledge?
- Do you have a growing fear that your child has become "out of control"?
- Do you fear that your child might injure him/herself or others?
- Do you "bargain" with your child in an attempt to change behavior?
- Do you feel heart-sick because you have had to compromise your own values or lower your expectations concerning your child?
- Do you find yourself desiring to spend less time at home to avoid conflicts with your child?

Total Checks from List Four: _____

Is there anything else you think we should know? _____

PARENT'S SIGNATURE

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PERMISSION TO CONTACT

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Permission to Contact

Chemical Dependency treatment is highly confidential and protected by federal laws. We feel that it is important to collaborate with other Kaiser Permanente health care providers for your best care. In order to communicate with relevant colleagues we need your permission.

I give permission to exchange information relevant to my child's Chemical Dependency treatment with my primary care physician.

YES NO

If yes, name of child's physician: _____

Facility: _____

This consent will expire in 12 months unless otherwise noted.

I, _____, give permission to Chemical Dependency

Services staff to:

Yes No

Contact me by phone at _____ if I miss scheduled appointments, classes, or other program services

Yes No

Leave a message at _____

Yes No

Contact me by letter if I miss scheduled appointments, classes, or other program services at

(include street address, city, state, and ZIP code)

Yes No

Take a photograph of me to be kept with my chart

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

DATE

WITNESS' 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