



Child, Adolescent and Family Services
Northern California

CHILD, ADOLESCENT, AND FAMILY DATA

Date: _____ IMPRINT AREA

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)
SCHOOL (NAME & ADDRESS)		SCHOOL DISTRICT	SCHOOL GRADE
NAME OF PERSON COMPLETING FORM		RELATIONSHIP	RELIGION
MOTHER'S NAME	MOTHER'S MR #	HOME PHONE	WORK PHONE
FATHER'S NAME	FATHER'S MR #	HOME PHONE	WORK PHONE
CHECK ONE: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried		IF DIVORCED, WHO HAS LEGAL CUSTODY?	
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:

_____	_____
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.

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? _____

HAS THERE BEEN ANY ABUSE OF THE CHILD?

- PHYSICAL NO YES
 SEXUAL NO YES
 EMOTIONAL 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
 VISITATION NOW PAST
 PROBATION NOW PAST
 CHILD PROTECTION NOW PAST
 ADOPTION 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 & 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		

continued on next page

BEHAVIOR CHECKLIST (continued)

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

Forms of discipline used:

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

Other: _____

School

Check any area of concern:

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

School environment:

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

Family stresses

Now or previously have there been:

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

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: _____

DEVELOPMENTAL HISTORY (continued)

Please indicate at what age your child:

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

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

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

MEDICAL HISTORY:

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

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

DOES YOUR CHILD HAVE OTHER MEDICAL CONDITIONS? NO YES

If yes, please describe: _____

DOES YOUR CHILD FREQUENTLY COMPLAIN OF BODILY ACHES AND PAINS? NO YES

If yes, please describe: _____

DOES YOUR CHILD MISS SCHOOL BECAUSE OF HIS/HER PHYSICAL COMPLAINTS? NO YES

If yes, please describe: _____

DOES YOUR CHILD HAVE ANY ALLERGIES TO MEDICATIONS/DRUGS? NO YES

If yes, please describe: _____

LIST ANY MEDICATIONS YOUR CHILD IS TAKING, THE DOSAGE, AND WHEN IT WAS STARTED.

FAMILY INFORMATION:

List all the people who live with the child now.

Name	Age	Relationship	Occupation/School grade

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: _____

SIGNATURE OF PARENT OR GUARDIAN

DATE



Location: _____

MR #:

Name:

CONFIDENTIALITY DISCLOSURE

IMPRINT AREA

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



MR #: _____
Name: _____

CONSENT TO TREATMENT

IMPRINT AREA

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