KAISER PERMANENTE®

ADULT BEHAVIORAL HEALTH QUESTIONNAIRE

00018541

PLEASE COMPLETE ALL THREE PAGES

IMPRINT ID CARD ABOVE

In order for the Mental Health Department to be of the best help to our patients, it is important that each person being seen for an evaluation complete the following questionnaire prior to seeing the therapist for the first visit.

All information in this questionnaire is kept strictly confidential in the Mental Health Department files. This form will not be placed in your general medical file and this information will not be available to any outside person except with your written consent.

You have the right to refuse to answer any question.

Name _____ Medical Record No.: _____ Date _____

Home Center: _____ Primary / Referring Physician: _____

Previous Mental Health visits to Kaiser-Permanente? ☐ No ☐ Yes, When? _____ Therapist's Name _____

Please list the main reasons you are seeking help at this time.

1. _____

2. _____

Have there been any significant life changes for you within the past year?

1. _____

2. _____

Present Address _____ City _____ State _____ Zip _____

Home Phone _____ Office Phone _____ Sex ____ Race ___ Religion _____ Birthdate _____ Age ___

Education (Circle Highest Grade Completed)

Elementary 1 2 3 4 5 6 7 8 High School 9 10 11 12 College 1 2 3 4 5+

Marital Status

☐ Never Married ☐ Married Now; How Long? _____ ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law

Number of Previous Marriages _____ How Long Married? _____ How Ended? _____

Current Occupation _____

Place of Employment _____

Current Status (Check One) ☐ Self Employed ☐ Other Employed ☐ Unemployed ☐ Housewife ☐ Student ☐ Retired ☐ Unable to Work

If Currently Employed, Do You: ☐ Work One Job ☐ Work More Than One Job

Are You Employed: ☐ Full Time ☐ Part Time

Length of Time on Present Job: _____ Years.

MEDICATION

Please list the medications you are currently taking, include reason for medication and length of time taken:

_____

_____

_____

Please list any medications that you are allergic to:

_____

_____

_____

SUBSTANCE USE

Do you smoke? ☐ Yes ☐ No ☐ Ex-Smoker

Have you ever drunk alcoholic beverages? ☐ Yes ☐ No

If yes, how often do you drink now? (please check)

_____ About once a year

_____ About once a month

_____ About once a week

_____ Almost every day

_____ Ex-drinker (abstinence of at least 6 months)

During the average week, how much do you drink?
(Please indicate the number of drinks of each type beverage)

_____ Beer _____ Wines _____ Hard Liquor

Have you used marijuana or other drugs? ☐ Yes ☐ No

If yes, how often?

Name(s) of Drug(s)

Less than once a year _____

About once a month _____

About once a week _____

Almost every day _____

Ex-drug user (no use for at least 6 months) _____

Were you ever treated for an emotional, alcohol or drug problem? ☐ Yes ☐ No

If yes, complete the following:

DATES OF TREATMENT AND DIAGNOSIS (If Known) OR REASON FOR TREATMENT	NAME OF THERAPIST AND/OR INSTITUTION (Clinic, Hospital, etc.)	NAME OF MEDICATION USED

Please list any of your relatives that have had any emotional, alcohol, or drug problems:

NAME	RELATIONSHIP TO YOU	DATES AND PLACE OF TREATMENT	DIAGNOSIS (If Known)

FAMILY HISTORY

	NAME	AGE	SEX	LIVING W/ YOU	IF NO, GIVE LOCATION IF DECEASED, GIVE AGE & CAUSE OF DEATH
Spouse				Yes ___ /No ___	
Children				Yes ___ /No ___	
				Yes ___ /No ___	
				Yes ___ /No ___	
				Yes ___ /No ___	
Stepchildren				Yes ___ /No ___	
				Yes ___ /No ___	
Parents				Yes ___ /No ___	
				Yes ___ /No ___	
Stepparent				Yes ___ /No ___	
Siblings				Yes ___ /No ___	
				Yes ___ /No ___	
				Yes ___ /No ___	

Is anyone else living in your home? ☐ Yes ☐ No Relationship: _____

_____

PERSONAL HISTORY

1. How was your health during childhood and adolescence? (please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor
   Please list current significant illnesses and any serious childhood illnesses with your age at the time.

   _____

   _____

   _____

   _____

2. Have you had any surgical operations or other hospitalizations? ☐ Yes ☐ No
   If yes, please list with date:

   _____

   _____

   _____

   _____

3. Have you had any serious accidents or injuries? ☐ Yes ☐ No
   If yes, please list with date:

   _____

   _____

   _____

   _____

4. Have you served in the United States Armed Forces? ☐ Yes ☐ No

   If yes, give number of years served: _____ Type of Discharge: _____

Patient's Signature: _____ Date: _____

Thank You