KAISER PERMANENTE®

Mental Health—Chemical Dependency Services
Intensive Outpatient Services

MR #: _____

Name: _____

DATE

# ADULT PERSONAL DATA SHEET

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| NAME | | | MEDICAL RECORD # | |
|---|---|---|---|---|
| ADDRESS | | | CITY | ZIP |
| HOME PHONE | WORK PHONE | CELL PHONE | OK TO LEAVE A MESSAGE? ☐ Yes ☐ No | |
| GENDER | SEXUAL ORIENTATION | | EDUCATIONAL LEVEL | |
| OCCUPATION | | | EMPLOYER | |
| CHECK ONE: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed | | | | |
| ETHNICITY | | | RELIGION | |
| EMERGENCY CONTACT | | | EMERGENCY PHONE | |

Do you have a work-related problem? ☐ Yes ☐ No

Are you currently on:

a) Workers' Compensation? ☐ Yes ☐ No
b) SSI? ☐ Yes ☐ No
c) State Disability? ☐ Yes ☐ No

**MAJOR REASONS FOR SEEKING HELP AT THIS TIME:**

Did someone refer you to this clinic? ☐ Yes ☐ No If yes, who? _____

What brings you to our clinic at this time? _____

How long have you had these problems or symptoms? _____

Why did you seek help now? _____

What have you already tried? _____

What important questions and concerns would you like addressed today? _____

Types of help desired: ☐ Therapy/Counseling ☐ Group Therapy ☐ Substance Use/Abuse Treatment ☐ Medication Treatment

☐ Other: _____

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**CHECK ITEMS BELOW THAT APPLY TO YOUR CURRENT AND PAST CONDITION(S).**
**PLEASE CHECK BOXES ONLY IF THEY APPLY TO YOU.**

| | Current | Past | | Current | Past |
|---|---|---|---|---|---|
| Feeling sad most of the time | ☐ | ☐ | Feeling people control your thoughts | ☐ | ☐ |
| Unable to enjoy things / have a good time | ☐ | ☐ | Feeling that someone is tricking you | ☐ | ☐ |
| Crying | ☐ | ☐ | Feeling strange | ☐ | ☐ |
| Fatigue / Low energy | ☐ | ☐ | Pain / Headaches | ☐ | ☐ |
| Trouble falling or staying asleep | ☐ | ☐ | Dizziness | ☐ | ☐ |
| Sleeping too much | ☐ | ☐ | Stomach / Bowel trouble | ☐ | ☐ |
| Too little or too much appetite | ☐ | ☐ | Tremors or tics | ☐ | ☐ |
| Gaining or losing weight | ☐ | ☐ | Major health problems | ☐ | ☐ |
| Changes in sex drive | ☐ | ☐ | Overly elated or euphoric mood | ☐ | ☐ |
| Other sexual problems | ☐ | ☐ | Feeling overly irritable and edgy | ☐ | ☐ |
| Poor concentration | ☐ | ☐ | Thoughts racing too fast | ☐ | ☐ |
| Memory problems | ☐ | ☐ | Limitless energy / Feeling wired | ☐ | ☐ |
| Feeling worthless | ☐ | ☐ | Mood swings | ☐ | ☐ |
| Thinking of killing yourself | ☐ | ☐ | Fantastic thoughts or plans | ☐ | ☐ |
| Planning a way to kill yourself | ☐ | ☐ | Doing things impulsively | ☐ | ☐ |
| Work problems | ☐ | ☐ | Being highly distractible | ☐ | ☐ |
| Relationship problems | ☐ | ☐ | Excessive or out-of-control spending | ☐ | ☐ |
| Conflict in family | ☐ | ☐ | Reduced need for sleep | ☐ | ☐ |
| Financial problems | ☐ | ☐ | Binge eating | ☐ | ☐ |
| Anxious | ☐ | ☐ | Throwing up or abusing laxatives | ☐ | ☐ |
| Worried most days | ☐ | ☐ | Avoiding eating | ☐ | ☐ |
| Sudden feelings of terror or panic | ☐ | ☐ | Compulsive eating | ☐ | ☐ |
| Scared to leave home or go outside | ☐ | ☐ | Being physically abused | ☐ | ☐ |
| Fears of one or more common things | ☐ | ☐ | Being sexually abused | ☐ | ☐ |
| Anxious in social situations | ☐ | ☐ | Violent / Aggressive behavior | ☐ | ☐ |
| Hoarding or clutter behavior | ☐ | ☐ | Thoughts of physically harming someone | ☐ | ☐ |
| Repetitive or compulsive behavior | ☐ | ☐ | Anger or explosive temper | ☐ | ☐ |
| Nightmares | ☐ | ☐ | Drug and/or alcohol cravings | ☐ | ☐ |
| Feeling restless | ☐ | ☐ | | | |
| Hearing sounds or voices others don't | ☐ | ☐ | | | |
| Seeing things that others don't | ☐ | ☐ | | | |
| Feeling people plot against you | ☐ | ☐ | | | |

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## PAST PSYCHIATRIC TREATMENT:

| Counseling or Psychotherapy? | No. | Type (Individual/Family)? | By Whom (Provider)? | Year(s) | Helpful? Yes | No |
|---|---|---|---|---|---|---|
| ☐ Yes ☐ Never | 1 | | | | ☐ | ☐ |
| | 2 | | | | ☐ | ☐ |
| | 3 | | | | ☐ | ☐ |
| | 4 | | | | ☐ | ☐ |
| | 5 | | | | ☐ | ☐ |

| Psychiatric Medication(s)? | No. | Name of Medication and Amount? | By Whom (Doctor)? | Year(s) | Yes | No |
|---|---|---|---|---|---|---|
| ☐ Yes ☐ Never | 1 | | | | ☐ | ☐ |
| | 2 | | | | ☐ | ☐ |
| | 3 | | | | ☐ | ☐ |
| | 4 | | | | ☐ | ☐ |
| | 5 | | | | ☐ | ☐ |
| | 6 | | | | ☐ | ☐ |

| Psychiatric Hospital Admissions? | No. | Where? | Why? | Year(s) | Yes | No |
|---|---|---|---|---|---|---|
| ☐ Yes ☐ Never | 1 | | | | ☐ | ☐ |
| | 2 | | | | ☐ | ☐ |
| | 3 | | | | ☐ | ☐ |
| | 4 | | | | ☐ | ☐ |
| | 5 | | | | ☐ | ☐ |
| | 6 | | | | ☐ | ☐ |

## MEDICAL HISTORY:

Do you have any serious or chronic medical conditions (including past surgeries)? ☐ Yes ☐ No

If yes, date(s) and details: _____

Do you have any serious medical accidents or injuries, head injury, or past seizures? ☐ Yes ☐ No

If yes, date(s) and details:

Are you currently taking any medications outside of Kaiser Permanente? ☐ Yes ☐ No

If yes, please list:

Have you had any allergic reactions to, or other problems with medications? ☐ Yes ☐ No

If yes, details:

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**SUBSTANCE USE:**

**Alcohol Use:** ☐ Yes ☐ No

a) How much at one time? _____ c) How many years have you been drinking? _____

b) How often? _____ d) Last drink taken (time and amount): _____

**Drug Use (recreational or street):** ☐ Yes ☐ No

a) What kind? _____ d) How much at one time? _____

b) How many years have you been using? _____ e) Last drug used (time and amount): _____

c) Have you abused prescription drugs? _____

**Tobacco:** ☐ Yes ☐ No If yes, how much use per day? _____

**Caffeine:** ☐ Yes ☐ No If yes, how much use per day? _____

Have you ever felt the need to cut down on your alcohol or drug use? ☐ Yes ☐ No

Have you ever felt annoyed by someone criticizing your drinking/drug use? ☐ Yes ☐ No

Have you ever felt guilty about your drinking/drug use? ☐ Yes ☐ No

Have you ever felt the need for a drink first thing in the morning? ☐ Yes ☐ No

Has drinking/drugs caused problems in your relationships or your job? ☐ Yes ☐ No

Have you ever been arrested for a DUI (Driving Under the Influence)? ☐ Yes ☐ No

Previous substance abuse treatment programs (please list): _____

**DO YOU HAVE PROBLEMS WITH (please check):**

☐ Stealing/Shoplifting ☐ Gambling ☐ Use of pornography ☐ High risk sexual behavior

Have you had any financial problems, legal difficulties/problems, or previous imprisonment? ☐ Yes ☐ No

If yes, dates and details: _____

**IN YOUR LIFE, HAVE YOU EVER HAD ANY EXPERIENCE THAT WAS SO FRIGHTENING, HORRIBLE, OR UPSETTING THAT, IN THE PAST MONTH, YOU:**

Have had nightmares about it or thought about it when you did not want to? ☐ Yes ☐ No

Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? ☐ Yes ☐ No

Were constantly on guard, watchful, or easily startled? ☐ Yes ☐ No

Felt numb or detached from others, activities, or your surroundings? ☐ Yes ☐ No

Have you ever been in an intimate relationship where there has been hitting, pushing, verbal put downs, threats, controlling behavior, and/or screaming? ☐ Yes ☐ No

Has anyone ever forced you to do or see sexual acts against your will? ☐ Yes ☐ No

Have relatives/significant others had psychiatric symptoms or drug or alcohol problems? ☐ Yes ☐ No

| Relative | Symptoms / Problems | Treatment | Psychiatric Medications | Psychiatric Hospitalizations |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**PATIENT SIGNATURE** **DATE**

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| PHQ-9<br>Over the last 2 weeks, how often have you been bothered by any of the following problems?<br>(Circle only one number per line.) | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself—or that you are a failure or have let yourself down or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you might be better off dead, or hurting yourself in some way | 0 | 1 | 2 | 3 |



**Add the circled numbers in each column; then add the sums:** 0 + ☐ + ☐ + ☐ = ☐ **A**

| | | | | |
|---|---|---|---|---|
| 10. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 11. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 12. Feeling unproductive at work or other daily activities | 0 | 1 | 2 | 3 |
| 13. Having trouble focusing on achieving your goals | 0 | 1 | 2 | 3 |

**Add the circled numbers in each column; then add the sums:** 0 + ☐ + ☐ + ☐ = ☐ B

## Global Distress Score (GDS): TOTAL (A + B) = ☐ A+B

| *If you have had* a visit in the Mental Health Department, circle the number that BEST matches your feelings about your most recent visit. | Only a little or not ot at all | Sometimes | Quite a bit | Totally |
|---|---|---|---|---|
| 1. In the session, we discuss the things that are most important to me | 0 | 1 | 2 | 3 |
| 2. I feel understood and respected by my clinician | 0 | 1 | 2 | 3 |
| 3. I understand and agree with my treatment plan | 0 | 1 | 2 | 3 |

**Goodness of Fit Score:** 0 + ☐ + ☐ + ☐ = ☐ **F**

KAISER PERMANENTE®

Location: _____

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## CONFIDENTIALITY DISCLOSURE

**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 |