KAISER PERMANENTE®

☒ **Psychiatry**

MR # _____

NAME_____

ENCOUNTER DATE	CLINICIAN'S NAME

NORTHERN CALIFORNIA

CHILD, ADOLESCENT, AND FAMILY DATA

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

CHILD/TEEN'S PREFERRED NAME	ETHNICITY	GENDER	AGE
ADDRESS (street, city, zip code)			
PERSON COMPLETING FORM	LEGAL GUARDIAN? Y N		
PRIMARY CAREGIVER'S NAME	RELATIONSHIP TO CHILD	BEST CONTACT NUMBER	
PRIMARY CAREGIVER'S NAME	RELATIONSHIP TO CHILD	BEST CONTACT NUMBER	
BIOLOGICAL PARENTS' NAMES (if different from above)			
SCHOOL NAME		SCHOOL GRADE	

ALL INDIVIDUALS WHO CURRENTLY LIVE WITH THE CHILD INCLUDING CAREGIVERS:
(PLEASE DENOTE IF SEPARATE HOUSEHOLDS)

NAME	AGE	RELATIONSHIP	OCCUPATION/ SCHOOL GRADE

CHILD'S MAIN PROBLEM/MAJOR REASONS FOR SEEKING HELP NOW:

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Please check the box or boxes that most closely describe your child. Please provide additional clarification as indicated.

DEVELOPMENTAL AND MEDICAL HISTORY

PREGNANCY, LABOR, DELIVERY PROBLEMS ☐ None ☐ Yes _____

_____

CHILD EXPOSURE DURING PREGNANCY ☐ None ☐ Alcohol ☐ Drugs ☐ Tobacco ☐ Accident ☐ Illness

DELAYS IN DEVELOPMENTAL MILESTONES ☐ None ☐ Talking ☐ Walking ☐ Toilet training

Specify: _____

BABY/INFANT BEHAVIOR

☐ Ate well ☐ Easy to soothe ☐ Wanted to be left alone
☐ Colicky ☐ Easy to regulate (sleep, eat) ☐ Dare-devil behavior
☐ Clumsy ☐ Adaptable to transitions ☐ Head banging
☐ Other: _____

MEDICAL PROBLEMS

☐ Allergies ☐ Operations ☐ Convulsions
☐ Asthma ☐ Poisoning ☐ Bladder/Bowel control
☐ Head injury ☐ Serious infection ☐ Ear infections
☐ Other: _____

CURRENT MEDICATIONS: _____

CURRENT SUPPLEMENTS, VITAMINS, AND HERBAL REMEDIES: _____

_____

CHILD'S PREVIOUS TREATMENT: ☐ None ☐ Individual Therapy ☐ Psychiatry (medication)

☐ Group Therapy ☐ Family Therapy ☐ Inpatient ☐ Residential (overnight)

IF ANY, PLEASE SPECIFY THE TREATMENT FOCUS AND PROVIDER(S):

_____

_____

_____

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PSYCHOSOCIAL HISTORY

	CURRENT	PAST		CURRENT	PAST
MARITAL PROBLEMS	☐	☐	DEATH OF A LOVED ONE	☐	☐
DIVORCE/SEPARATION	☐	☐	SERIOUS FAMILY ILLNESS	☐	☐
CUSTODY DISPUTES	☐	☐	PARENT ALCOHOL/DRUG USE	☐	☐
FINANCIAL PROBLEMS	☐	☐	JOB LOSS	☐	☐
HOUSING PROBLEMS	☐	☐	OTHER:	☐	☐

FIREARMS IN ANY HOME YOUR CHILD RESIDES	☐ No ☐ Yes IF YES, HOW ARE THEY SECURED?_____
SOCIAL SKILLS WITH PEERS	☐ Poor ☐ Average ☐ Good ☐ Unknown
BEHAVIOR WITH SIBLINGS	☐ Poor ☐ Average ☐ Good ☐ N/A
BEHAVIOR WITH PARENTS/GUARDIANS	☐ Poor ☐ Average ☐ Good ☐ Unknown
JUVENILE JUSTICE INVOLVEMENT	☐ No ☐ Yes _____
EXERCISE PER *DAY* (average)	☐ 0 ☐ 30 min ☐ 1-2 hrs ☐ 3 hrs or more
MEDIA USE PER *DAY* (average hours) (e.g., videogames, phone, computer, television)	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ 8 or more
CAFFEINE DRINKS PER *DAY* (e.g., coffee, soda, energy drinks)	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 or more
SLEEP PER *NIGHT* (average hours)	☐ less than 5 ☐ 6-7 ☐ 8-10 ☐ 11-12
SUBSTANCE USE (past or present)	☐ None ☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Other
DISCIPLINE STRATEGIES ☐ Helpful most of the time ☐ Not helpful most of the time	☐ Verbal reprimands/discussions ☐ Remove privileges ☐ Physical punishment ☐ Time out ☐ Grounding ☐ Reward/incentives

Please describe any *current or past* abuse.	None	Verbal (put downs, controlling)	Physical (hits, threatens to hit)	Sexual (pressured or forced)
CHILD ABUSE	☐	☐	☐	☐
WITNESSED VIOLENCE AT HOME	☐	☐	☐	☐
DATING VIOLENCE	☐	☐	☐	☐
PEER VIOLENCE (bullying, cyber-bullying)	☐	☐	☐	☐

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EDUCATIONAL HISTORY

ACADEMIC PERFORMANCE ☐ Poor ☐ Average ☐ Above Average ☐ Unknown

ATTITUDE TOWARDS SCHOOL ☐ Poor ☐ Average ☐ Above Average ☐ Unknown

ACADEMIC SERVICES

☐ Home and hospital
☐ Independent study
☐ Gifted program
☐ Speech therapy
☐ Resource classes/Special education
☐ 504 Plan
☐ Individualized Education Plan (IEP)

SCHOOL PROBLEMS

☐ Learning problems:_____
☐ Works hard, but does not do well
☐ Repeated grade (Grade: _____)
☐ Frequent discipline referrals or detention
☐ Suspensions/Expulsions (# _____)
☐ Other school problems:_____
_____

Please check who of the child's *biological* family members had these conditions in the past or present. Please specify other biological relatives in the *others* column.

	MOTHER	FATHER	OTHERS (siblings, aunt, uncle grandparent)
Childhood inattention, over-activity, or poor impulse control	☐	☐	
Learning disabilities	☐	☐	
Developmental delays or Autism Spectrum Disorders	☐	☐	
Schizophrenia or psychosis	☐	☐	
Depression (2+ weeks), Mood Swings, or Bipolar Disorder	☐	☐	
Suicide attempts or completion	☐	☐	
Anxiety or OCD	☐	☐	
Tics/Tourettes	☐	☐	
Alcohol or Drug abuse	☐	☐	
Antisocial (assaults to family & others, thefts, arrests)	☐	☐	

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Please check the items below that were significant ***past* problems for your child/teen.**

- ☐ Hard to focus and pay attention
- ☐ Feeling sad, depressed, or irritable
- ☐ Often angry at others
- ☐ Doing things that get them into trouble
- ☐ Excessive mood or aggressive behavior problems
- ☐ Risk or safety concerns
- ☐ Hard time controlling their words or behaviors
- ☐ Often worried or anxious
- ☐ Experienced or witnessed a traumatic event
- ☐ Problem with eating or body image
- ☐ Periods of extreme panic or fear
- ☐ Social or developmental problems

Please check the items below that are significant ***current* problems for your child/teen.**

Is it hard for your child to focus and pay attention?
☐ No (skip section) ☐ Yes (complete items below)

- ☐ Make careless mistakes or does not pay attention to details
- ☐ Problems paying attention/staying focused
- ☐ Avoids, dislikes, or is reluctant to complete tasks that require sustained mental effort (homework, chores)
- ☐ Problems with organization
- ☐ Lose things easily
- ☐ Forgetful
- ☐ Easily distracted
- ☐ Does not listen when spoken to directly
- ☐ Does not follow through on instructions or work

Is your child feeling sad, depressed, or irritable?
☐ No (skip section) ☐ Yes (complete items below)

- ☐ Depressed or irritable mood much of the time
- ☐ Problems sleeping
- ☐ Fatigue or loss of energy
- ☐ Decreased interest or pleasure in activities
- ☐ Increased/Decreased appetite
- ☐ Increased/Decreased physical activity
- ☐ Feeling worthless or excessively guilty
- ☐ Problems thinking, concentrating, or being indecisive

Is your child often angry at others?
☐ No (skip section) ☐ Yes (complete items below)

- ☐ Blame others for my mistakes
- ☐ Angry most of the time
- ☐ Easily annoyed by others
- ☐ Go against adult requests or rules
- ☐ Back talk or argue with adults
- ☐ Deliberately annoys people
- ☐ Lose temper
- ☐ Desire to hurt others or get revenge

Does your child have a hard time controlling their words or behaviors?
☐ No (skip section) ☐ Yes (complete items below)

- ☐ Fidgets with hands or feet or squirms in seat
- ☐ Leaves classroom or other seat inappropriately
- ☐ Excessively runs about, climbs, or is restless
- ☐ Difficulty playing quietly
- ☐ Always "on the go"
- ☐ Talks excessively
- ☐ Blurts out answers to questions
- ☐ Difficulty awaiting turn
- ☐ Interrupts or intrudes on others

Is your child often worried or anxious?
☐ No (skip section) ☐ Yes (complete items below)

- ☐ Excessive anxiety or worry (about past behaviors, future events, competence)
- ☐ Phobia or extreme fear
- ☐ Excessive fear of social situations or public speaking
- ☐ Avoids social situations or public speaking
- ☐ Avoids or refuses to go to school
- ☐ Persistent worry about harm to family members
- ☐ Excessive distress when separated from family
- ☐ Persistent refusal to sleep alone
- ☐ Repeated nightmares about separation from family
- ☐ Repeating behaviors (e.g., counting, washing)

Has your child experienced or witnessed a traumatic event (i.e., car, accident, death, earthquake)?
☐ No (skip section) ☐ Yes (complete items below)

- ☐ Ongoing negative thoughts about what happened
- ☐ Ongoing negative feelings about what happened
- ☐ Recurrent distressing dreams about the event
- ☐ Flashbacks about the event
- ☐ Attempts to avoid memories, thoughts, or feelings about what happened

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Does your child do things that get them into trouble?
☐ No (skip section) ☐ Yes (complete items below)

☐ Bully or threaten others
☐ Get in physical fights
☐ Hurt animals
☐ Stole things
☐ Set a fire
☐ Destroyed property
☐ Broke into a house, building, car
☐ Stay out all night
☐ Ran away
☐ Truant from school
☐ Problems with the law or police
☐ Used an object as a weapon
☐ Lies to obtain goods/favors or avoid obligations

Does your child have excessive mood or aggressive behavior problems?
☐ No (skip section) ☐ Yes (complete items below)

☐ Excessive mood swings
☐ Racing thoughts
☐ Aggressive behavior
☐ Chronic irritability
☐ Violent nightmares
☐ Explosive temper outbursts (verbal or physical)

Does your child have any risk or safety concerns?
☐ No (skip section) ☐ Yes (complete items below)

☐ Self-injury (e.g., cutting, burning)
☐ Thoughts of death or suicide
☐ Suicide attempt
☐ Thoughts of harming or killing others
☐ Hearing voices or seeing things that are not there

Does your child have any additional concerns?
☐ No (skip section) ☐ Yes (complete items below)

☐ Motor or vocal tics
☐ Repeated urination in bed or clothes
☐ Repeated stool holding or soiling
☐ Other: _____

Does your child have a problem with eating or body image?
☐ No (skip section) ☐ Yes (complete items below)

☐ Fear of weight gain or being fat
☐ Trying to lose weight
☐ Unhappy with body weight or shape
☐ Purging/Self-induced vomiting
☐ Use of diet pills, laxatives, excessive exercise
☐ Overeat/Binge
☐ Excessively restricts food intake

Does your child have periods of extreme panic or fear?
☐ No (skip section) ☐ Yes (complete items below)

☐ Palpitations, pounding heart, accelerating heart rate
☐ Sweating
☐ Trembling or shaking
☐ Sensations of shortness of breath
☐ Nausea/abdominal distress
☐ Feeling dizzy, unsteady, lightheaded, faint
☐ Chills or heat sensations
☐ Fear of dying
☐ Constant worry of panic sensations returning

Does your child have social or developmental problems?
☐ No (skip section) ☐ Yes (complete items below)

☐ Problems responding to or interacting with others
☐ Problems understanding or lack of nonverbal gestures
☐ Poor eye contact
☐ Problems developing and maintaining relationships
☐ Lack of interest in other children
☐ Repetitive motor movements
☐ Overreacts to changes in routine
☐ Extremely restricted interest or activities
☐ Reacts excessively to noise or touch

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POQ - Pediatric Outcomes Questionnaire *Parent/Caregiver Version* (for ages 6-18)

Please answer each item by circling one number per row.

In the past 7 days…….

		Never	Almost Never	Some-times	Often	Almost Always
1.	My child felt unhappy.	0	1	2	3	4
2.	My child could not stop feeling sad.	0	1	2	3	4
3.	My child felt lonely.	0	1	2	3	4
4.	My child thought that his/her life was bad.	0	1	2	3	4
5.	My child felt everything in his/her life went wrong.	0	1	2	3	4
6.	My child felt like he/she couldn't do anything right.	0	1	2	3	4

Sum of items 1-6 = ☐

7.	My child felt scared.	0	1	2	3	4
8.	My child felt like something bad could happen.	0	1	2	3	4
9.	My child felt nervous.	0	1	2	3	4
10.	My child felt worried.	0	1	2	3	4

Sum of items 7-10 = ☐

11.	My child felt mad.	0	1	2	3	4
12.	My child felt like hitting something.	0	1	2	3	4
13.	My child lost his/her temper easily.	0	1	2	3	4

Sum of items 11-13 = ☐

Global Distress Score (TOTAL of three boxes above) = ☐

PLEASE WAIT until your clinician asks you to complete these items.

		Not at all	Only a little	Sometimes	Quite a bit	Completely
1.	I talked about what I wanted.	0	1	2	3	4
2.	I felt really understood.	0	1	2	3	4
3.	I understand and agree with the plan about what to do.	0	1	2	3	4

Sum of items 1-3 = ☐

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Describe the impact of your child's problems on the family:

_____

_____

_____

_____

Describe your child's strengths and unique qualities:

_____

_____

_____

_____

Describe your family strengths and supports (e.g., friends, spiritual and cultural considerations):

_____

_____

_____

_____

What are you hoping to get out of being here (e.g., improve child's mood, help with anger, work on relationships)?

_____

_____

_____

_____

How important is this change for you? *(Please circle a number.)*

Not at all **Completely**

0 1 2 3 4 5 6 7 8 9 10

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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 ("the 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 law protects the confidentiality of chemical dependency records. See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal laws and 42 CFR part 2 for federal regulations. 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 the Program.

Coordination of Care

At Kaiser Permanente Mental Health and Chemical Dependency services staff operate under one department, the Department of Psychiatry, and are considered one Program. Therefore, any MH/CD information can be shared between Mental Health staff and Chemical Dependency staff without your written consent. However, the regulations pertaining to mental health patient information differ from those 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, such as your primary care physician. Mental Health diagnoses and appointment dates are available to your other 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 treating providers.

For these reasons, your medication visits, the list of medications, laboratory results, a description of medication results, limited notes regarding your treatment and prognosis are included in your medical record, either on paper or electronically and may be shared with your other treatment providers.

Exceptions to Confidentiality Rules

The law authorizes us to disclose limited information about your treatment in the MH/CD Program without your consent, to certain persons and in certain circumstances:

- in medical and psychiatric emergencies in which the information is essential to an individual's safety
- to qualified personnel for audit, program evaluation, or research
- 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
- to other Kaiser Permanente departments who provide administrative and clinical support to the MH/CD Program and which have agreed to abide by the federal chemical dependency confidentiality rules.

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