KAISER PERMANENTE

Department of Psychiatry, Santa Rosa, CA
Northern California

Name: _____

MR#: _____

INTAKE QUESTIONNAIRE

DATE

Imprint Area

Name:
Medical Record Number:
Preferred phone number to reach you:
Is it okay to leave a message? ☐ Yes ☐ No (Please check one)

Reason(s) for seeking help at this time? _____

What have you tried to help with the above problem(s)? _____

Is there anything specific you are looking for? (check all that apply)

Psychotherapy?	☐ Yes	☐ No	☐ Maybe	☐ Not Sure
Medication?	☐ Yes	☐ No	☐ Maybe	☐ Not Sure
Advice Only?	☐ Yes	☐ No	☐ Maybe	☐ Not Sure

Past Psychiatric History: _____

Prior Psychiatric Medications? ☐ Yes ☐ No (If yes, please list type, dosage, and dates, if known)

Prior Psychotherapy? ☐ Yes ☐ No (If yes, please list provider(s) and dates, if known)

Prior Psychiatric Hospitalizations? ☐ Yes ☐ No (If yes, please list location(s) and dates)

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How much have the following problems bothered you ***in the past week?*** Please check your answer.	Not at all	A little bit	Somewhat	Very Much	Extremely
SA Scale 6*					
	0	**1**	**2**	**3**	**4**
Fear of embarrassment causes me to avoid doing things or speaking to people.	☐	☐	☐	☐	☐
I avoid activities in which I am the center of attention.	☐	☐	☐	☐	☐
Being embarrassed or looking stupid are my worst fears.	☐	☐	☐	☐	☐
PD Scale 11*					
It scares me when I feel shaky.	☐	☐	☐	☐	☐
It scares me when I feel faint.	☐	☐	☐	☐	☐
It scares me when my heart beats rapidly.	☐	☐	☐	☐	☐
It scares me when I become short of breath.	☐	☐	☐	☐	☐
PHO Scale 5					
I avoid (or feel distress in) situations for fear of getting trapped or that I may have panic and not get help.	☐	☐	☐	☐	☐
I have phobias (excessive or unreasonable fears of specific situations or objects). Describe specific phobia:	☐	☐	☐	☐	☐
TRA Scale 9					
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that ***in the past month*** you had any of the following					
I have had nightmares about the event or thought about it when I did not want to.	☐	☐	☐	☐	☐
I tried hard not to think about it or went out of my way to avoid situations that reminded me of the event.	☐	☐	☐	☐	☐
I have been constantly on guard, watchful, or easily startled.	☐	☐	☐	☐	☐
I have felt numb or detached from others, activities, or my surroundings.	☐	☐	☐	☐	☐

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Please rate how much you agree with each item. Please check your answer. **OCD Scale 7**	Not at all	A little bit	Somewhat	Very Much	Extremely
	0	**1**	**2**	**3**	**4**
Rate any: I am bothered by ideas, images, or impulses that seem silly, weird, nasty, or horrible and I have trouble getting rid of them; or I fear doing something impulsively that might cause embarrassment or harm.	☐	☐	☐	☐	☐
I check things too much (e.g. locks, switches, the stove) or do calculations repeatedly.	☐	☐	☐	☐	☐
Rate any: I need to do things in a ritualized way or have things exactly symmetrical or repeat actions until it feels "just right".	☐	☐	☐	☐	☐
BPD Scale 3					
I engage in behaviors that harm my body (e.g. cutting, hitting or scratching self).	☐	☐	☐	☐	☐
I have intense feelings of anger that I have difficulty controlling.	☐	☐	☐	☐	☐
I react impulsively in ways that are either self damaging or damaging of my relationships.	☐	☐	☐	☐	☐
SOM Scale 9					
I have headaches.	☐	☐	☐	☐	☐
I have stomach problems.	☐	☐	☐	☐	☐
I have muscle or joint pains.	☐	☐	☐	☐	☐
MA Scale 6					
I have gone for days at a time with excessive energy, little or no sleep, and have not felt tired.	☐	☐	☐	☐	☐
I have had periods of euphoria or irritability, where my thoughts raced and I could not slow my thinking down.	☐	☐	☐	☐	☐
I have had trouble with grandiose plans, spending sprees, sexual acting out, or other impulsive behavior that seemed right at the time.	☐	☐	☐	☐	☐

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Please rate how much you agree with each item. Please circle your answer.	Not at all	A little bit	Somewhat	Very Much	Extremely
AD Scale 9					
	0	**1**	**2**	**3**	**4**
I have been impaired much of my life by difficulty in finishing projects I have started.	☐	☐	☐	☐	☐
I have been impaired much of my life by a lack of organization.	☐	☐	☐	☐	☐
I have been impaired much of my life by problems focusing on tasks.	☐	☐	☐	☐	☐
I have been impaired much of my life by poor time management.	☐	☐	☐	☐	☐
EDO Scale 3					
I engage in compulsive/binge eating (i.e. eating more than twice what others might eat in a single sitting).	☐	☐	☐	☐	☐
I use purging, laxatives, or extreme exercise to control my weight.	☐	☐	☐	☐	☐
I have a history of not eating with excessive weight loss.	☐	☐	☐	☐	☐
PSY Scale 2					
I believe that others can put thoughts into my head.	☐	☐	☐	☐	☐
I hear voices talking to me or calling my name when no one is around.	☐	☐	☐	☐	☐
Sometimes I receive messages from the TV or radio that are specifically directed at me.	☐	☐	☐	☐	☐
SUI Scale 6					
I have thoughts of suicide.	☐	☐	☐	☐	☐
I have a specific plan to commit suicide.	☐	☐	☐	☐	☐
I have a current intent to commit suicide.	☐	☐	☐	☐	☐
I have guns in my home. ☐ Yes ☐ No (Check One)					
Prior history of suicide attempts? ☐ Yes ☐ No (Check One)					
IPA Scale 2					
In your relationship has there been any hitting, insulting, threatening to hurt, or screaming?	☐	☐	☐	☐	☐
I do not feel safe in my home.	☐	☐	☐	☐	☐

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Over the last two weeks, how often have you been bothered by any of the following problems? Please circle your answer.	Not at all	Several days	More than half the days	Nearly every day
PHQ9*10				
	0	**1**	**2**	**3**
Little interest or pleasure in doing things?	☐	☐	☐	☐
Feeling down, depressed, or hopeless?	☐	☐	☐	☐
Trouble falling asleep or staying asleep, or sleeping too much?	☐	☐	☐	☐
Feeling tired or having little energy?	☐	☐	☐	☐
Poor appetite or overeating?	☐	☐	☐	☐
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
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?	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐
TOTAL PHQ9				
AXFX				
Feeling nervous, anxious or on edge.	☐	☐	☐	☐
Not being able to stop or control worrying.	☐	☐	☐	☐
Feeling unproductive at work or other daily activities.	☐	☐	☐	☐
Having trouble focusing on achieving your goals.	☐	☐	☐	☐
TOTAL AXFX				
AOQ*11 PHQ9 plus AXFX ---- TOTAL AOQ				

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Alcohol or Other Drug Use:		
In the last 12 months, have you abused alcohol or drugs?		
Do you have a drug or alcohol problem?	☐ Yes	☐ No
If you drink alcohol, please indicate current use (one drink equals 1 shot of liquor, 1 beer, or 1 glass of wine) ☐ 4 or more drinks per day, ☐ 3-1 drinks per day, ☐ 1 drink per day, ☐ less than 5/week		
Last drink (time and amount):		
Do you use drugs (including marijuana)?		
If yes, what drugs?		
How much?	How often?	
Have you ever tried cutting down on your drinking/drug use?	☐ Yes	☐ No
Have you ever felt angry/annoyed when asked about your drinking/drug use?	☐ Yes	☐ No
Have you ever felt guilty about your drinking/drug use?	☐ Yes	☐ No
Have you ever been arrested for a DUI?	☐ Yes	☐ No

Occupation:			Employer:		
How long have you lived in this area?			Last grade of school completed?		
Are you:	☐ Married	☐ Partnered	☐ Single	☐ Divorced	☐ Widowed
Ethnicity?			Religion?		

Family Data

Name	Check if living with you	Age, if living	Occupation	History of Mental Illness (if any) Please describe
Spouse/Partner				
	☐			
Children				
	☐			
	☐			
	☐			
	☐			
Any other family members with mental health issues				
	☐			
	☐			
	☐			

KAISER PERMANENTE®

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:

SIGNED: PATIENT'S OR REPRESENTATIVE'S SIGNATURE	DATE:
Print name and relationship to patient (if signed by authorized representative of the patient)	DATE:

Please bring signed copy and print out a copy for your records