PARENT INTAKE PACKET

INFORMED CONSENT FOR THERAPY SERVICES

Welcome to the Anxiety Treatment Center, LLC. In this packet, you will find a number of questionnaires that will help us to learn more about your child.

About The Anxiety Treatment Center, LLC

We specialize in cognitive behavioral therapy, or CBT, which is proven to be effective for many anxiety-related problems. This form of treatment focuses on teaching your child to learn healthier ways of coping with stressful situations, change the way he/she thinks in critical situations, and gradually confront the things he/she fears in order to feel less afraid. Repeated studies have shown that CBT leads to reduction of symptoms, enhanced quality of life, and positive changes in brain functioning.

CBT differs from other forms of psychological therapy in several ways. First, CBT is a collaborative and active therapy, meaning that you, your child, and your treatment provider will work together toward reducing your child's symptoms. Therefore, parent participation in some of the treatment sessions will be required, and what is discussed and learned in treatment sessions is intended to be practiced outside of those sessions. By learning to apply new skills in everyday life, significant changes are more likely to occur. Second, whereas some other treatments focus on understanding the reasons behind your child's symptoms, CBT focuses on how your child is thinking, behaving, and communicating presently and emphasizes teaching your child how to make him/herself feel better. Third, CBT is designed to be time-limited rather than ongoing like some other forms of therapy.

Your child's first visit will consist of a thorough assessment of his/her problems. This is done in order to make sure that your child receives the right kind of treatment and to assist in developing an individualized treatment plan. You and your child will work with your treatment provider to identify specific goals during the evaluation phase. These goals can be modified as you continue. After the assessment, your provider will recommend a course of treatment. You should evaluate this information and decide if you feel comfortable working with the treatment provider. If you have questions about your provider's procedures, you are encouraged to discuss them whenever they arise.

We want you and your child to know as much as possible about your child's condition and the treatment your child is receiving. Your treatment provider will share information, but you are also encouraged to ask questions such as: What is the name of my child's condition? How common is it? What kinds of treatment are available for this condition? What evidence is there to show that this treatment will be helpful? We believe that people who are well informed will make the best choices and will benefit the most from treatment. If you have any unanswered questions about any of the procedures used in the course of your child's treatment, please do not hesitate to ask for clarification. We wish you a productive experience and hope that the time you spend with us results in changes that are positive, meaningful, and long-lasting.

If you are unhappy with what is happening in therapy, we encourage you to talk with your child's treatment provider so that he/she can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that the provider refer you to another clinician and you are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about the treatment provider's specific training and experience.

Risks & Benefits of Treatment

In general, there is little risk participating in CBT. But, because the process of therapy often requires exploring unpleasant feelings, emotions, and experiences your child is likely to experience uncomfortable feelings, such as worry, anger, frustration, sadness, guilt, and/or helplessness. These feelings may be more frequent and intense during the early stages of treatment and will likely lessen and become more tolerable as treatment progresses. Your child may also be encouraged to confront situations he/she would rather avoid, which can lead to temporary stress or anxiety. There is always a risk that your child's symptoms will return. If they do, his/her CBT skills should make it easier for him/her to manage them. So, it is important to keep practicing the skills, even after your child feels better.

CBT has been shown to have benefits for those who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, and improved skills for managing stress and resolving specific problems. CBT requires active effort and is most effective when you and your child are motivated and engage in the assigned home activities between sessions.

Professional Records

We are required to keep appropriate records of the psychological services that we provide. Records are maintained in a secure location in the office. We keep brief records noting the reasons for seeking therapy, diagnoses, medical, social, and treatment history, session dates, treatment goals and progress, topics discussed in treatment sessions, records we receive from other providers, copies of records we send to others, and billing records. You have the right to a copy of your child's file upon request. Because these are professional records, they may be misinterpreted by untrained readers. For this reason, we recommend that you initially review them with your treatment provider, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Confidentiality

All of the information you and your child provide to us, whether verbal or written, is considered confidential by state law and by the ethical principles of the American Psychological Association. Individuals aged 18 and older have the legal right to keep information pertaining to their treatment private from their parents; individuals under 18 do not have this right. While parental involvement can be an essential treatment component, privacy in therapy is vital to enhance the therapeutic process and contribute to positive gains. If your child is 14 or older, you may be asked to sign an agreement allowing the details of your child's therapy sessions to remain private. In these cases, general information about the treatment plan and progress will be shared. All other communication will require your child's consent to share, unless your treatment provider feels there is a safety concern, in which case he/she will make every effort to

inform your child of his/her intention to disclose information to you and make every effort to handle any objections that are raised by your child.

Information about your child cannot be given out to other parties, such as schools or doctors, without your written permission. The exceptions to this rule are if there is an immediate risk of harm to your child or to others, if the treatment provider has reason to suspect child abuse or neglect, or if your child's records are subpoenaed by a court of law. If you choose to communicate with us via email, please be aware that it is not considered a secure form of communication, and the confidentiality of any information sent via email cannot be guaranteed. If your child's treatment provider is working under supervision, the provider will discuss your child's case with his/her supervisor. More information about your and your child's privacy rights is detailed in the Notice of Privacy Practices.

Contacting Us

Our treatment providers are often not immediately available by telephone. We do not answer our telephones when we are with clients or outside of our individual office hours. At these times, you may leave a message on your provider's confidential voice mail and your call will be returned as soon as possible. If, for any unforeseen reason, you do not hear from your provider or your provider is unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep your child safe, 1) call 211 and press 1 to access a 24-hour-a-day crisis intervention and support service or 2) call 911 or go to your local hospital's Emergency Room. Our providers make every attempt to inform clients in advance of planned absences.

Child Care

We regret that our staff cannot provide child care. Therefore, if you have young children who are not clients at the Anxiety Treatment Center, LLC, please arrange to have someone care for them during your appointment.

If you have any additional questions about the Anxiety Treatment Center, LLC, CBT, or other issues, please ask your treatment provider.

Please sign below to indicate that you have read and agree to the above information and consent to the procedures described above:

_____ _____

Parent/Guardian's Signature Date

Please sign below to indicate that you have received a copy of our Privacy Policy:

_____ _____

Parent/Guardian's Signature Date

The purpose of this packet is to help us get more information about your child and his/her concerns. Please answer all of these questions to the best of your ability. If you do not understand a question, please circle it and ask your clinician about it.

Dear Parents:

Having you carefully fill in this form now will help us to reduce the time and cost of gathering this information at our office. We appreciate your cooperation and patience.

Child's Name:_____ Age:_____ Today's Date: _____

Address: _____ City: _____

State: _____ Zip: _____ How long at this address? _____

Child's sex: _____ Child's birthplace: _____ Birthdate: _____

Child's race: (please check)

☐ American Indian or Alaskan ☐ Black, not of Hispanic origin

☐ Hispanic ☐ Native Asian or Pacific Islander

☐ White, not of Hispanic origin

Person completing this form: _____ Relation to child: _____

Bio Father's Name: _____ Age: _____ Education: _____

Employed: _____ Work Phone: _____

Type of work: _____ Home Phone: _____

Bio Mother's Name: _____ Age: _____ Education: _____

Employed: _____ Work Phone: _____

Type of work: _____ Home Phone: _____

Please describe the problems for which you are seeking help at this time (you may continue on the back)**.**

Therapy History

Has your child ever received inpatient or outpatient treatment for this problem?

If yes, please list in order, including names, addresses, and phone numbers. Include psychological testing.

Name	Dates	Address	Phone #

Has your child ever received Cognitive Behavioral Therapy?

How would you describe the effectiveness of this treatment?

☐ Much improvement ☐Some improvement ☐ No improvement

Who referred you here?

Name: _____

Address: _____

Phone Number: _____

Additional Demographics:

Child's Primary Residence:

Living with: ☐ Both parents ☐Father ☐ Mother ☐Other _____

Is your child adopted?

If yes, please describe the circumstances of the adoption:

School Information:

Name of school: _____ Phone Number:_____

Teacher's name: _____ Grade: _____

Type of school: ☐ Public ☐ Private ☐ Special

List previous schools, dates attended, and indicate overall performance (academic and behavioral):

_____ Performance: ☐ Poor ☐ Fair ☐ Good

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_____ Performance: ☐ Poor ☐ Fair ☐ Good

_____ Performance: ☐ Poor ☐ Fair ☐ Good

Grades repeated _____ Grades skipped _____ Expelled? ☐ No ☐ Yes

If Yes, # of times? _____

Any known learning disabilities or special programs? ☐ No ☐ Yes If yes, explain:

Which of the following problems, if any, does your child have in school?

☐ Does not do homework ☐ Starts but does not finish homework \

☐ Fails to check homework ☐ Poor handwriting ☐ Poor spelling

☐ Poor math ☐ Poor reading skills ☐ Makes many careless errors

☐ Messy and disorganized ☐ Does not remain seated ☐ Incomplete classroom work

☐ Poor attention in class ☐ Non-compliant in class ☐ Talks out inappropriately in class

☐ Distracted ☐ Test anxiety ☐ Problems with written languag

☐ Forgets assignments ☐ Excessive time to complete assignments

Interactions with peers:

☐ No friends ☐ Few friends ☐ Loses friends

☐ Mean, aggressive ☐ Bossy, controlling ☐ Trouble making new friends

☐ Too Shy or too timid ☐ Risky behaviors

Family Medical History

Do medical illnesses run in your families? (examples: seizures, thyroid problems, allergies)

☐ No ☐ Yes

If yes, please describe, including treatment:

Medication History

Has your child ever taken psychiatric medications? ☐No ☐Yes If yes, please list:

	Medication	**Medication**
Drug Name		
Given by Whom		
When Started		
When Stopped		
For What Problems?		
Dose		
Benefits		
Side Effects		
Results		

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Pregnancy

While you were pregnant with this child, were you under a doctor's care? ☐ No ☐ Yes

Mother's age at time of birth: _____ yrs.

Father's age at time of birth: _____ yrs.

Was the delivery unusual in any way? ☐ No ☐ Yes How?

Developmental History: (*Answer as best as you can remember)*

Motor Development (sitting, crawling, walking)

☐ Normal ☐ Fast ☐ Slow

Speech and Language

☐ Normal ☐ Fast ☐ Slow

Handedness

☐ Normal ☐ Fast ☐ Slow

Self-help Skills (dressing, brushing, toileting, hygiene)

☐ Normal ☐ Fast ☐ Slow

Bowel Trained:

☐ Average ☐ Early ☐ Late

Bladder Trained:

☐ Average ☐ Early ☐ Late

Eating Behavior:

☐ Picky ☐ Eats too much ☐ Overeats sugar/carbohydrates

Temperament (Infancy, Toddler, Pre-School): Check any that apply

☐ Shy or timid ☐ Fearful ☐ Impulsive ☐ Rocking

☐ Stubborn ☐ Cautious ☐ Poor sleep ☐ Head banging

☐ Affectionate ☐ Underachieve ☐ Curious ☐ Into everything

☐ Temper Outbursts ☐ Overactive ☐ Tore up toys more than usual

☐ Daredevil ☐ Easy to manage ☐ Slow to warm up ☐ Wanted to be left alone

☐ Poor eating ☐ Aggressive ☐ Happy ☐ Blank Spells

☐ Falling spells ☐ More interested in things than people

Family Psychiatric History (Please note: Major Depression, Bipolar Disorder, Obsessive-Compulsive Disorder, Tic Disorders, other Anxiety Disorders, Schizophrenia, Substance Abuse, Suicide Attempts, and other Psychiatric problems)

Has the child's **mother or mother's relatives** had similar or other psychiatric problems?

If yes, please describe, including treatment:

Has the child's **father or father's relatives** had similar or other psychiatric problems?

If yes, please describe, including treatment:

Does the child's brother(s) or sister(s) have any psychiatric problems?

If yes, please describe, including treatment:

Medical History of Child: Does your child take any current medication for a medical illness:

If yes, please describe:

CGI RATING

<u>Over the past week</u>, how severe is your child's problem for which you are seeking help? (Circle one)

1	2	3	4	5	6	7
Normal, there is no problem	**Borderline problem**	**Mild problem**	**Moderate problem**	**Marked problem**	**Severe problem**	**Extreme problem**

SHEEHAN INVENTORY-CHILD:

For each area, circle the number that best describes YOUR CHILD'S situation now.

SCHOOLING: Because of my child's problems, his/her schooling is impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at all	*Mildly*			*Moderately*			*Markedly*			*Very severely (cannot go to school)*

SOCIAL LIFE/LEISURE ACTIVITIES (with other people at parties, socializing, visiting, dating, outings, clubs, entertaining): Because of my child's problems, his/her social life is impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at all	*Mildly*			*Moderately*			*Markedly*			*Very severely (I never do these)*

FAMILY LIFE/HOME RESPONSIBILITIES (relating to family members, doing household chores, following family rules): Because of my child's problems, his/her family life/home responsibilities are impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at all	*Mildly*			*Moderately*			*Markedly*			*Very severely (I never do these)*

SHEEHAN INVENTORY-PARENT:

For each area, circle the number that best describes YOUR situation now.

WORK: Because of my child's problems, MY work is impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at all	*Mildly*			*Moderately*			*Markedly*			*Very severely (cannot work)*

SOCIAL LIFE/LEISURE ACTIVITIES (with other people at parties, socializing, visiting, dating, outings, clubs, entertaining): Because of my child's problems, MY social life is impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at all	*Mildly*			*Moderately*			*Markedly*			*Very severely (I never do these)*

FAMILY LIFE/HOME RESPONSIBILITIES (relating to family members, paying bills, managing home, shopping, and cleaning): Because of my child's problems, MY family life/home responsibilities are impaired:

0	1	2	3	4	5	6	7	8	9	10
Not at all	*Mildly*			*Moderately*			*Markedly*			*Very severely (I never do these)*

ADIS-IV SCREENING QUESTIONNAIRE

This form will ask you about problems that you may have had. Please respond to each question by circling "Yes," "No," or "Maybe/Unsure."

	CIRCLE ONE:		
SR: Does your child have problems attending or staying in school?	YES	NO	MAYBE/UNSURE
SAD: When your child is not with you, does he/she let you know, or have you notices, that he/she feels really scared or worried and does whatever he/she can to be with you?	YES	NO	MAYBE/UNSURE
SAD: Does your child get very upset, cry, or beg you to stay home when you plan to go somewhere without him/her?	YES	NO	MAYBE/UNSURE
SAD: When you leave your child, does he/she cry or tell you he/she feels very bad because he/she misses you a lot?	YES	NO	MAYBE/UNSURE
SAD: When you go out somewhere and leave your child with a babysitter, friends, or relatives, do they tell you that your child cried while you were gone or felt very bad because he/she missed you?	YES	NO	MAYBE/UNSURE
SAD: When you know that you are going to be away from home, does your child get upset ahead of time and then worry about your leaving?	YES	NO	MAYBE/UNSURE
SoP: When your child is in certain social situations with other people in school, in restaurants, at parties, or when meeting new people, has he/she told you, or have you notices, that he/she is afraid that people might think something he/she does is stupid or dumb	YES	NO	MAYBE/UNSURE

or that they might laugh at him/her?

SoP: When your child is in these situations with other people, do you know whether he/she worries that he/she might do something that will be embarrassing?	YES	NO	MAYBE/UNSURE
SpP: Does your child fear or feel a need to avoid such things as flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects?	YES	NO	MAYBE/UNSURE
PD: Has your child had times when he/she felt very frightened for no apparent reason or "out of the blue?"	YES	NO	MAYBE/UNSURE
AG: Are there any places your child doesn't like to go because he/she is afraid that he/she will all of a sudden get scared and he/she won't be able to get away or to get help?	YES	NO	MAYBE/UNSURE
AG: Does your child fear going places like shopping malls or crowded places, because he/she is afraid of having an uncomfortable feeling in his/her body, such as dizziness or a fast-beating heart, and then he/she won't be able to escape or get help?	YES	NO	MAYBE/UNSURE
GAD: Does your child always seem to be worrying about things like school and how well they are doing, things that can happen in the future, their friends, their family, or other things?	YES	NO	MAYBE/UNSURE
OCD: Is your child bothered by thoughts, images, or impulses that keep recurring to him/her that seem inappropriate or nonsensical but that he/she can't stop from coming into his/her mind?	YES	NO	MAYBE/UNSURE
OCD: Does your child feel driven to repeat some behavior or to repeat something in his/her mind over and over again to try to feel less uncomfortable?	YES	NO	MAYBE/UNSURE
PTSD: Has your child ever experienced or witnessed a traumatic or life-threatening event such as assault, sexual molestation, seeing someone badly injured or killed, combat, accidents, or natural or man-made disasters?	YES	NO	MAYBE/UNSURE
DyD: Has your child ever experienced an entire year of feeling sad and blue, or he/she was irritable more days than he/she felt good?	YES	NO	MAYBE/UNSURE

DyD: Has your child been feeling sad more days than he/she has been feeling good this past year?	YES	NO	MAYBE/UNSURE
MDE: Has your child ever experienced a period of two weeks or more when he/she felt depressed, sad, empty, or lost interest or pleasure in his/her usual activities?	YES	NO	MAYBE/UNSURE
MaE: Has your child ever experienced a period of several days or more when he/she felt unusually or excessively high or irritable?	YES	NO	MAYBE/UNSURE
AD: Does your child often make little mistakes, such as on school work, chores, or other things that he/she does?	YES	NO	MAYBE/UNSURE
AD: Is your child easily distracted?	YES	NO	MAYBE/UNSURE
AD: Does your child have trouble listening to other people?	YES	NO	MAYBE/UNSURE
AD: Is it difficult for your child to finish things that others ask him/her to do, such as chores, homework, and so on?	YES	NO	MAYBE/UNSURE
AD: Does your child usually have difficulty staying in his/her seat?	YES	NO	MAYBE/UNSURE
AD: Do you often have to reprimand your child for acts such as climbing on the furniture, running through the house, or constantly being on the go?	YES	NO	MAYBE/UNSURE
AD: Does your child have trouble sitting and doing things by him/herself quietly?	YES	NO	MAYBE/UNSURE
AD: Does your child often seem restless?	YES	NO	MAYBE/UNSURE
AD: Does your child often start one thing and then go on to something else before it is finished?	YES	NO	MAYBE/UNSURE
AD: Is your child overly talkative?	YES	NO	MAYBE/UNSURE
AD: Does your child usually answer a question before the person has finished asking it?	YES	NO	MAYBE/UNSURE
AD: Is it hard for your child to wait for his/her turn when playing games or in groups?	YES	NO	MAYBE/UNSURE
AD: Does your child “butt into” things too much?	YES	NO	MAYBE/UNSURE

CD: Does your child do things such as break rules, steal, lie, act aggressively toward other people or animals, or destroy things that belong to others?	YES	NO	MAYBE/UNSURE
OD: Does your child always seem angry, often lose his/her temper, always argue, frequently try to annoy other people, and often refuse outright to do what he/she is told or asked to do?	YES	NO	MAYBE/UNSURE
SM: Does your child refuse to speak at school or in other social situations? For example, does he/she refuse to answer questions in school or refuse to respond when persons other than family members speak to him/her?	YES	NO	MAYBE/UNSURE
ENU: After reaching age 5, has your child had the problem of wetting his/her pants or bed either during the day or at night?	YES	NO	MAYBE/UNSURE
STD: Has your child ever woken up in the middle of the night with a panicky scream, feeling really scared because he/she had a terrible nightmare, but he/she doesn't clearly remember what the nightmare was all about?	YES	NO	MAYBE/UNSURE
ETOH: Does your child drink alcohol, such as beer or wine?	YES	NO	MAYBE/UNSURE
SA: Does your child smoke pot or use any other illegal drug?	YES	NO	MAYBE/UNSURE
SZ: Did your child ever tell you that he/she heard voices when no one else was around?	YES	NO	MAYBE/UNSURE
SZ: Did your child ever tell you that he/she saw things that were not really there?	YES	NO	MAYBE/UNSURE
SZ: Did your child ever tell you that people were doing things to pester him/her or to hurt him/her, so he/she felt as if he/she had to be on the lookout?	YES	NO	MAYBE/UNSURE
SZ: Is it sometimes difficult to understand your child because he/she talks in a mixed up way or because what he/she says doesn't make any sense?	YES	NO	MAYBE/UNSURE
MR: Is your child performing significantly below his/her grade level in school?	YES	NO	MAYBE/UNSURE
LD: Does your child have difficult in school due to reading, mathematics, or writing problems?	YES	NO	MAYBE/UNSURE

PDD: Does your child have difficulties dealing with social interactions? For example, does he/she seem awkward in social interactions, fail to respond to others, or seem uninterested in socializing?	YES	NO	MAYBE/UNSURE
PDD: Does your child have difficulty communicating with others? For example, was he/she delayed in his/her speech abilities or does he/she have difficulty initiating or following conversations?	YES	NO	MAYBE/UNSURE
PDD: Is your child overly preoccupied with repeating things, such as certain body movements, routines, or rituals? Or does he/she get very preoccupied with certain objects or parts of objects?	YES	NO	MAYBE/UNSURE
ED: Does your child think that his/her weight is what it should be for his/her age?	YES	NO	MAYBE/UNSURE
ED: Do you think your child wishes that he/she could be thinner than he/she is now?	YES	NO	MAYBE/UNSURE
ED: Does your child worry a lot about his/her weight?	YES	NO	MAYBE/UNSURE
ED: Does your child find it difficult to control his/her eating?	YES	NO	MAYBE/UNSURE
ED: Does your child have times when he/she goes without eating (fasting) so that he/she can control his/her weight?	YES	NO	MAYBE/UNSURE
ED: Does your child ever go on diets, use medications or laxatives, exercise for hours, or try to vomit to control his/her weight?	YES	NO	MAYBE/UNSURE
HYP: Is your child always worrying that he/she might have a serious disease or illness (e.g., cancer, AIDS)?	YES	NO	MAYBE/UNSURE
HYP: Does your child have any feelings (symptoms) or pains in his/her body that he/she thinks could be something serious?	YES	NO	MAYBE/UNSURE
SOM: Does your child go to the doctor often because of many different physical complaints?	YES	NO	MAYBE/UNSURE