ADOLESCENT INTAKE PACKET

CONSENT FOR THERAPY SERVICES

Welcome to the Anxiety Treatment Center, LLC. This packet contains a lot of questions that will help us get to know you better. The purpose of meeting with a counselor or therapist is to get help with problems that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to someone about these problems. Or, you may be here because your parent, doctor, or school counselor thinks it will be helpful.

What to Expect

When you come for your first visit, your therapist will ask you questions and listen to you to understand you and your problems better. At the end of the first meeting, your therapist will suggest a plan for how you can work together to improve these problems. We want you to feel free to ask as many questions as you want. Some questions you could ask are: Do I have a problem? If so, what is it called? How common is it? What can I do about it?

In general, there is little risk participating in therapy. But, because the process of therapy often requires exploring unpleasant feelings, emotions, and experiences you are 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. You may also be encouraged to confront situations that you would rather avoid, which can lead to temporary stress or anxiety. Therapy has many benefits, including fewer feelings of distress, better relationships, and improved skills for managing stress and resolving problems. Part of successful treatment includes trying out the things that are discussed during treatment sessions in your daily life.

Confidentiality

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 parent participation can be an important part of treatment, it is important that you feel comfortable talking to your therapist about the issues that are bothering you. Sometimes these issues will include things you don't want your parents to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their therapist. Privacy, also called confidentiality, is an important and necessary part of good treatment. Your therapist will make every effort to be clear about your privacy and will discuss confidentiality openly with you and your parents at the beginning of treatment. Your provider will work with you and your parents to come to an agreement about what kinds of information can be kept private. However, you should be aware that Connecticut law allows your parents to access your treatment records if they wish.

Your therapist will not share any information with other adults unless he/she has your permission and written permission from your parent. Sometimes your therapist may request to

speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for your therapist to give suggestions to your teacher or school counselor. Sometimes your doctor and your therapist may need to work together; for example, if you are prescribed medication. A very unlikely situation might come up in which your therapist does not have your permission but your therapist and your parents agree that that it is very important for your therapist to be able to share certain information with school staff or a doctor. In this situation, your therapist will use his/her professional judgment to decide whether to share any information.

In some situations, your therapist is required by law or by the guidelines of his/her profession to disclose information whether or not he/she has your permission. We have listed these situations below.

Confidentiality **cannot** be maintained when:

- You tell your therapist you plan to cause serious harm or death to yourself, and he/she believes you have the intent and ability to carry out this threat in the very near future. Your therapist must take steps to inform a parent of what you shared and how serious he/she believes the threat to be. Your therapist must make sure you are protected from harming yourself.

- You tell your therapist you plan to cause serious harm or death to someone else, and your therapist believes you have the intent and ability to carry out this threat in the very near future. In this situation, your therapist must inform your parent, the appropriate authorities, and, when identified, the person who you intend to harm.

- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, your therapist will need to use his/her professional judgment to decide whether your parent and other appropriate authorities should be informed.

- You tell your therapist you are being abused (physically, sexually or emotionally) or neglected. In this situation, your therapist is required by law to report the abuse to the Connecticut Department of Children and Families.

- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, your therapist will not disclose information without written permission *unless* the court requires him/her to do so. Your therapist will do all he/she can within the law to protect your confidentiality, and if he/she is required to disclose information to the court, he/she will inform you that this is happening.

You can always ask your therapist questions about the types of information he/she would disclose. You can ask in the form of “hypothetical situations,” in other words: “If someone told you that they were doing _____, would you tell their parents?”

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

_____ _____

Adolescent’s Signature Date

The purpose of these questions is to help us get more information about you and your 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 us about it.

Name: _____ Age: _____

What kind of problem(s) would you like us to help you with?

_____

_____

_____

_____

_____

How long has this been going on?

_____

What have you done to cope? Has it been helpful?

_____

_____

_____

What do you hope to gain from this evaluation and therapy?

_____

_____

_____

CGI SELF RATING

<u>Over the past week</u>, how bad is the problem you would like us to help you with? (Circle one)

1	2	3	4	5	6	7
There is no problem	Barely a problem	A little problem	A medium problem	A pretty bad problem	A very bad problem	An extremely bad problem

These questions ask whether anxiety or other problems have MESSED UP things. MESSED UP means the problems you are having make it hard for you to do well in school, do things with your friends, get along with your family, or do chores at home. For each area, circle the number that best describes your situation now.

SCHOOLING: Because of my problems, my schooling is messed up:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (cannot go to school)

SOCIAL LIFE/LEISURE ACTIVITIES (with other people at parties, socializing, visiting, outings, participation in clubs/activities): Because of my problems, my social life is messed up:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (I never do these)

FAMILY LIFE/HOME RESPONSIBILITIES (relating to family members, doing household chores, following family rules): Because of my problems, my family life/home responsibilities are messed up:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (I never do these)

HEALTH HABITS

Sleep

Average hours of sleep per night: _____

Please check any sleep problems that you have experienced in the past month:

☐ Difficulty falling asleep ☐ Difficulty getting out of bed

☐ Difficulty staying asleep ☐ Not feeling rested in the morning

Appetite/Eating

Have you experienced any changes in your eating or appetite? ☐ Yes ☐ No

If YES, please describe: _____

Do you think your weight is what it should be for someone your age? ☐ Yes ☐ No

Do you worry a lot about your weight? ☐ Yes ☐ No

Please check any behaviors that you have engaged in during the past month:

☐ Difficulty controlling your eating ☐ Binging/Eating a lot of food at one time

☐ Dieting, using medications or laxatives, exercising a lot, or vomiting to control your weight/avoid weight gain

Substance Use

Do you drink alcohol? ☐ Yes ☐ No

If yes, *how much* and *how often* do you drink? _____

Do you use tobacco products? ☐ Yes ☐ No

If yes, *how often* do you use tobacco products? _____

Do you use other substances? ☐ Yes ☐ No

If yes, *which substances* and *how often* do you use these substances? _____

_____

_____

Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐ Yes ☐ No
Do you ever use drugs or alcohol to relax, feel better about yourself, or fit in?	☐ Yes ☐ No
Do you ever use drugs or alcohol while you are by yourself?	☐ Yes ☐ No
Do you ever forget things you did while using alcohol or drugs?	☐ Yes ☐ No

Do your family or friends ever tell you that you should cut down on your drinking or drug use?	☐ Yes ☐ No
Have you ever gotten into trouble while you were using alcohol or drugs?	☐ Yes ☐ No

RISK ASSESSMENT

1. Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next question.

How often do you have these feelings? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? ☐ Yes ☐ No

If YES, please describe: _____

Do you currently feel that you don't want to live? ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before? ☐ Yes ☐ No

2. Have you ever hurt your body (e.g., cut, carve, burn, scratch really hard, punch) on purpose but without wanting to end your life? ☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next question.

When was the last time you intentionally hurt yourself? _____

Approximately on how many total occasions have you intentionally hurt yourself? _____

How old were you the first time you intentionally hurt yourself? _____

On what areas of your body have you intentionally hurt yourself? _____

3. Have you ever had feelings or thoughts of hurting or harming someone else?
☐ Yes ☐ No

4. Have you ever been involved with the legal system? ☐ Yes ☐ No

If YES, please describe: _____

_____

5. Have you ever been abused? (check all that apply)

☐ Verbally ☐ Physically ☐ Emotionally ☐ Sexually ☐ Neglected

MASC^2

Multidimensional Anxiety Scale for Children, Second Edition
By John S. March, M.D., MPH

These sentences ask how you might have been thinking, feeling, or acting recently. For each item, please circle **how often the sentence is true about you**.

Circle OFTEN if a sentence is true about you a lot of the time.
Circle SOMETIMES if a sentence is true about you some of the time.
Circle RARELY if a sentence is true about you once in a while.
Circle NEVER if a sentence is hardly ever true about you.

Remember, there are no right or wrong answers, just answers about how you might have been feeling recently.

1.	I feel tense or uptight.	never	rarely	sometimes	often
2.	I usually ask permission to do things.	never	rarely	sometimes	often
3.	I worry about other people laughing at me.	never	rarely	sometimes	often
4 .	I get scared when my parents go away.	never	rarely	sometimes	often
5 .	I keep my eyes open for danger.	never	rarely	sometimes	often
6.	I have trouble getting my breath.	never	rarely	sometimes	often
7.	The idea of going away to camp scares me.	never	rarely	sometimes	often
8 .	I get shaky or jittery.	never	rarely	sometimes	often
9.	I try to stay near my mom or dad.	never	rarely	sometimes	often
10 .	I'm afraid that other kids will make fun of me.	never	rarely	sometimes	often
11.	I try hard to obey my parents and teachers.	never	rarely	sometimes	often
12.	I get dizzy or faint feelings.	never	rarely	sometimes	often
13.	I check things out first.	never	rarely	sometimes	often
14.	I worry about getting called on in class.	never	rarely	sometimes	often
15.	I'm jumpy.	never	rarely	sometimes	often
16.	I'm afraid other people will think I'm stupid.	never	rarely	sometimes	often
17.	I keep the light on at night.	never	rarely	sometimes	often
18.	I have pains in my chest.	never	rarely	sometimes	often

19.	I avoid going to places without my family.	never	rarely	sometimes	often
20.	I feel strange, weird, or unreal.	never	rarely	sometimes	often
21.	I try to do things other people will like.	never	rarely	sometimes	often
22.	I worry about what other people think of me.	never	rarely	sometimes	often
23.	I avoid watching scary movies and TV shows.	never	rarely	sometimes	often
24.	My heart races or skips beats.	never	rarely	sometimes	often
25.	I stay away from things that upset me.	never	rarely	sometimes	often
26.	I sleep next to someone from my family.	never	rarely	sometimes	often
27.	I feel restless and on edge.	never	rarely	sometimes	often
28	I try to do everything exactly right.	never	rarely	sometimes	often
29.	I worry about doing something stupid or embarrassing.	never	rarely	sometimes	often
30.	I get scared riding in the car or on the bus.	never	rarely	sometimes	often
31.	I feel sick to my stomach.	never	rarely	sometimes	often
32.	I get nervous if I have to perform in public.	never	rarely	sometimes	often
33.	Bad weather, the dark, heights, animals, or bugs scare me.	never	rarely	sometimes	often
34.	My hands shake.	never	rarely	sometimes	often
35.	I check to make sure things are safe.	never	rarely	sometimes	often
36.	I have trouble asking other kids to play with me.	never	rarely	sometimes	often
37.	My hands feel sweaty or cold.	never	rarely	sometimes	often
38.	I feel shy.	never	rarely	sometimes	often
39.	I have trouble making up my mind about simple things.	never	rarely	sometimes	often
40.	I get upset over the thought that I might get sick.	never	rarely	sometimes	often
41.	I have bad or silly thoughts that I can’t stop.	never	rarely	sometimes	often
42.	I have to do things over and over again for no reason.	never	rarely	sometimes	often

43.	I get really upset about dirt, germs, chemicals, radiation, or sticky things.	never	rarely	sometimes	often
44.	I feel that I have to wash or clean more than I really need to.	never	rarely	sometimes	often
45.	I fear I'll be responsible for something bad happening.	never	rarely	sometimes	often
46.	I have to check that nothing terrible has happened.	never	rarely	sometimes	often
47.	I have to check things several times or more.	never	rarely	sometimes	often
48.	I count things for no reason.	never	rarely	sometimes	often
49.	I get too concerned with sin or wrongdoing.	never	rarely	sometimes	often
50.	I have to repeat things until it feels just right.	never	rarely	sometimes	often

CDI^2

Children's Depression Inventory 2nd Edition
By Maria Kovacs, Ph.D.

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick **one** sentence that describes you best for the past **two weeks**. After you pick a sentence from the first group, go on to the next group.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this ✕ next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how the form works. Try it.
Put a mark next to the sentence that describes you best.

Example:

☐ I READ BOOKS ALL THE TIME

☐ I READ BOOKS ONCE IN A WHILE

☐ I NEVER READ BOOKS

Remember, for each group, pick out the sentence that describes you best in the **PAST TWO WEEKS**.

1. ☐ 0 I am sad once in a while. ☐ 1 I am sad many times. ☐ 2 I am sad all the time.	5. ☐ 0 I am important to my family. ☐ 1 I am not sure if I am important to my family. ☐ 2 My family is better off without me.
2. ☐ 2 Nothing will ever work out for me. ☐ 1 I am not sure if things will work out for me. ☐ 0 Things will work out for me O.K.	6. ☐ 2 I hate myself. ☐ 1 I do not like myself. ☐ 0 I like myself.
3. ☐ 0 I do most things O.K. ☐ 1 I do many things wrong. ☐ 2 I do everything wrong.	7. ☐ 2 All bad things are my fault. ☐ 1 Many bad things are my fault. ☐ 0 Bad things are not usually my fault.
4. ☐ 0 I have fun in many things. ☐ 1 I have fun in some things. ☐ 2 Nothing is fun at all.	8. ☐ 0 I do not think about killing myself. ☐ 1 I think about killing myself but would not do it. ☐ 2 I want to kill myself.

Remember, for each group, pick out the sentence that describes you best in the **PAST TWO WEEKS**.

9. [2] I feel like crying every day. [1] I feel like crying many days. [0] I feel like crying once in a while.	17. [2] Most days I do not feel like eating. [1] Many days I do not feel like eating. [0] I eat pretty well.
10. [2] I feel cranky all the time. [1] I feel cranky many times. [0] I am almost never cranky.	18. [0] I do not worry about aches and pains. [1] I worry about aches and pains many times. [2] I worry about aches and pains all the time.
11. [0] I like being with people. [1] I do not like being with people many times. [2] I do not want to be with people at all.	19. [0] I do not feel alone. [1] I feel alone many times. [2] I feel alone all the time.
12. [2] I cannot make up my mind about things. [1] It is hard to make up my mind about things. [0] I make up my mind about things easily.	20. [2] I never have fun at school. [1] I have fun at school only once in a while. [0] I have fun at school many times.
13. [0] I look O.K. [1] There are some bad things about my looks. [2] I look ugly.	21. [0] I have plenty of friends. [1] I have some friends but I wish I had more. [2] I do not have any friends.
14. [2] I have to push myself all the time to do my schoolwork. [1] I have to push myself many times to do my schoolwork. [0] Doing school work is not a big problem.	22. [0] My schoolwork is alright. [1] My school work is not as good as before. [2] I do very badly in subjects I used to be good in.
15. [2] I have trouble sleeping every night. [1] I have trouble sleeping many nights. [0] I sleep pretty well.	23. [2] I can never be as good as other kids. [1] I can be as good as other kids if I want to. [0] I am just as good as other kids.
16. [0] I am tired once in a while. [1] I am tired many days. [2] I am tired all the time.	24. [2] Nobody really loves me. [1] I am not sure if anybody loves me. [0] I am sure that somebody loves me.

Remember, for each group, pick out the sentence that describes you best in the **PAST TWO WEEKS**.

25. [0] It is easy for me to get along with friends. [1] I get into arguments with friends many times. [2] I get into arguments with friends all the time.	27. [2] Most days I feel like I can't stop eating. [1] Many days I feel like I can't stop eating. [0] My eating is O.K.
26. [2] I fall asleep during the day all the time. [1] I fall asleep during the day many times. [0] I almost never fall asleep during the day.	28. [0] It is easy for me to remember things. [1] It is a little hard to remember things. [2] It is very hard to remember things.

SCREENING QUESTIONNAIRE

This section 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: Do you get very nervous or scared about having to go to school?	YES	NO	MAYBE/UNSURE
SR: Do you stay home from school because you are nervous or scared?	YES	NO	MAYBE/UNSURE
AG: Are you afraid to go places like shopping malls or crowded places, because you are afraid of having an uncomfortable feeling in your body, such as dizziness or a fast-beating heart, and then you wouldn't be able to escape or get help?	YES	NO	MAYBE/UNSURE
PTSD: Have you ever experienced or seen a terrible or very dangerous event such as assault, sexual abuse, seeing someone badly injured or killed, accidents, or disasters?	YES	NO	MAYBE/UNSURE
MaE: Have you ever felt unusually "high" or cranky for several days at a time?	YES	NO	MAYBE/UNSURE
AD: Do you often make little mistakes, such as on school work, chores, or other things that you do?	YES	NO	MAYBE/UNSURE
AD: When you are supposed to be paying attention	YES	NO	MAYBE/UNSURE

to one thing, do you find yourself paying attention to other things?

AD: Do people often complain that you don't listen or pay attention?	YES	NO	MAYBE/UNSURE
AD: Do you find that you just can't finish things that others ask you to do, such as chores, homework, and so on?	YES	NO	MAYBE/UNSURE
AD: Do you usually have a lot of trouble staying in your seat?	YES	NO	MAYBE/UNSURE
AD: Do you get yelled at because you run around a lot or climb on things, such as the furniture?	YES	NO	MAYBE/UNSURE
AD: Do you often feel restless, like you need to keep moving or doing something?	YES	NO	MAYBE/UNSURE
AD: Do you have trouble playing quietly?	YES	NO	MAYBE/UNSURE
AD: Do you have trouble sitting and doing things quietly by yourself?	YES	NO	MAYBE/UNSURE
AD: Are you almost always moving your hands and feet?	YES	NO	MAYBE/UNSURE
AD: Do you often feel restless?	YES	NO	MAYBE/UNSURE