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Intake Packet and Informed Consent

Dear Parents,

Welcome to CBT Solutions of Baltimore. In this packet, you will find a number of questions that will help us to learn more about your child.

We specialize in cognitive-behavioral therapy (CBT). CBT differs from other forms of psychological therapy in several ways. First, CBT is an active therapy, meaning that your child and your therapist will work toward reducing symptoms, often out in the community. It is a common practice for parents and other family members to get involved in the CBT process, but the extent of family involvement depends on the child's age, child and parents' wishes, and the therapist's discretion. Second, CBT emphasizes learning how to eliminate, reduce and manage symptoms. Third, CBT is designed to be time-limited rather than ongoing like some other forms of therapy.

CBT has been proven to be an effective treatment for many psychological problems, including anxiety-related and obsessive-compulsive spectrum conditions. CBT focuses on teaching your child new skills and behaviors, helping your child practice those skills in a variety of situations, communicating healthier ways of coping with stressful situations, increasing awareness of thinking patterns in critical situations, and helping make changes to problematic thinking patterns.

Please note that CBT is not for everyone. Some children and families would prefer other types of treatment approaches, such as supportive psychotherapy, interpersonal psychotherapy, or psychodynamic psychotherapy. That is, please be aware that CBT is not the only option of therapy and that you may seek alternative approaches elsewhere. Your CBT Solutions provider may determine that CBT is not the only or best approach for your care, and at his or her discretion, may utilize other approaches for facilitating

your child's treatment. Please do not hesitate to ask about treatment techniques if any questions arise.

Your first visit will consist of a thorough assessment of your child's difficulties. This is done in order to make sure that your child receives the appropriate type of treatment. After the assessment, your clinician will recommend a course of treatment. You and your child will have the opportunity to ask questions, and to decide whether you agree with the clinician's recommendations.

We want you and your child to know as much as possible about your child's difficulties and how treatment works. Your therapist will provide this information, but you are also encouraged to ask questions such as the following: What is the name of my child's difficulties? How common is it? What kinds of treatments are available for this problem? 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.

Confidentiality

All of the information that you and your child provide to us, whether verbal, written, or on tape, is considered confidential by law and by the ethical principles of the American Psychological Association. Information cannot be given out to other parties without the written permission of a legal guardian (if the child is less than 16 years old) or by the child (if the child is 16 or 17 years old). Individuals who are age 16 and 17 may elect to be treated as an adult when it comes to confidentiality (e.g., including what can and cannot be disclosed to parents), although this decision is ultimately made at the discretion of the provider and can be changed at any time.

The legal exceptions to confidentiality include immediate risk of harm to the child or to other people, if abuse of a child or elderly individual is suspected, threats to the safety or wellbeing of the therapist, or if records are subpoenaed by a court of law. Information may be disclosed to third parties for payment purposes (e.g., billing third parties, sending delinquent accounts to a collection agency).

Electronic Communication

The extent to which technology and electronic communication is used as part of psychological services is based on the discretion of the individual provider. It can be instituted or revoked at any time. Some patients prefer the use of technology (e.g., email, text messaging, video conferencing) as part of clinical services, whereas others do not. Please consult with your child's individual provider about you or your child's preferences on this matter. However, by signing this consent form, you are providing your approval for corresponding with staff of CBT Solutions via electronic means, such as text and email. You also agree not to use electronic means for communicating with staff of CBT Solutions while you travel outside the State of Maryland.

Please be aware of several limitations of electronic communication that may affect confidentiality and psychological services.

1. Most forms of electronic communication are not encrypted, do not meet the standards of HIPAA, and are may be freely available in the public domain (e.g., some forms of email). CBT Solutions will apply standard security techniques to protect your health information (e.g., smart phone security for access; password protection), but please note that CBT Solutions cannot guarantee the protection of certain electronic communication (e.g., text messages) in the event that electronic devices are stolen or hacked. It is also possible for your child's health information to be disseminated to others on accident due to malware, viruses, user-error, etc. Also, since electronic communication requires at least two parties, the extent to which you and your child secure electronic messages and devices on your end and are comfortable with associated software (e.g., email program) and hardware (e.g., smart phone) also affects treatment and the protection of medical information. CBT Solutions is not responsible for data breaches that occur as a result of patient error.
2. Please also note that electronic communications are part of the medical record and can be subpoenaed.
3. Many electronic forms of communication can be unreliable (e.g., loss of internet connection or cell services), which means services can be disrupted. This can have an impact on psychological services.
4. Never use electronic communication, such as email or text, in the event of a mental health emergency. Please go to the nearest emergency room or call 911.
5. Note that many third party payers (e.g., insurance companies) will not reimburse you for services rendered electronically (e.g., phone sessions, video conferencing sessions, email fees).
6. Other people can assume you or your child's identity (i.e., identity theft) during electronic communication as part of psychological services. CBT Solutions may require confirmation of you or your child's identity if we suspect identity theft.
7. Most forms of electronic communication (e.g., text messaging, emailing) lack verbal and non-verbal communication cues, like facial expressions and tone. This can cause messages to be misinterpreted.
8. Asynchronous communication (i.e., messages that are NOT received and communicated in real-time) require at least 48 business hours for turnaround.

Childcare

We regret that our staff cannot provide child care. Therefore, if you have young children, please arrange to have someone take care of them during appointments.

If you have questions about CBT Solutions, CBT, or other issues, please ask your provider.

Emergencies

CBT Solutions is a group of outpatient mental health service providers. We are not designed to provide emergency mental health services. That is, CBT Solutions does not have an emergency pager or message service system; nobody is on-call. In the event of a mental health emergency, please go to your nearest emergency room or call 911.

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

_____ _____
Parent/Guardian's Signature Date

<u>Please also read and sign:</u>

I, the undersigned legal representative, hereby authorize CBT Solutions, LLC to use or disclosure my child's health information including information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information to other clinical providers responsible for my child's mental health care and general healthcare.

_____ _____
Parent/Guardian's Signature Date

The purpose of this packet is to help us get more information about your child's difficulties and treatment history. 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 child's provider about it.

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?
□no □yes

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? □ No □Yes

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? □ No □ Yes

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

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 □ Forgets assignments □ Messy and disorganized

□ Does not remain seated □ Incomplete classroom work □ Poor attention in class

□ Non-compliant in class □ Talks out inappropriately in class □ Problems with written language

□ Distracted □ Test anxiety □ Makes many careless errors □ Excessive time to complete assignments

Interactions with peers:

□ No friends □ Few friends □ Loses friends □ Trouble making new friends □ Mean, aggressive □ Too Shy or too timid □ Bossy, controlling □ 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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Drug Name		
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When Started		
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For What Problems?		
Dose		
Benefits		
Side Effects		
Results		

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 □ Wanted to be left alone □ Easy to manage □ Slow to warm up □ Daredevil □ More interested in things than people □ Happy □ Aggressive □ Poor eating □ Blank Spells □ Falling spells

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?
□ No □ Yes If yes, please describe, including treatment:

_____

_____

_____

Has the child's **father or father's relatives** had similar or other psychiatric problems?
□ No □ Yes If yes, please describe, including treatment:

_____

_____

_____

Does the child's brother(s) or sister(s) have any psychiatric problems?
□ No □ Yes If yes, please describe, including treatment:

_____

_____

_____

Medical History of Child: Does your child take any current medication for a medical illness: □ No □ Yes If yes, please describe:

_____

_____

_____

_____

_____

CGI PARENT RATING

Over the past week, 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**