

Intake Form for Child/Adolescent Psychotherapy

Child's name: _____ DOB/Age: _____ / _____

Child primarily lives with: Both parents Mother Father Other _____

Mother's name: _____ DOB: _____

Address: _____

Phone: (C) _____ (H) _____

Employer: _____

Custody: _____

Please list others living in mother's home, ages, and relationship to child:

Father's name: _____ DOB: _____

Address: _____

Phone: (C) _____ (H) _____

Employer: _____

Custody: _____

Please list others living in father's home, ages, and relationship to child:

Step-parent's/Guardian's information: (If applicable) _____

Address: _____

Phone: (C) _____ (H) _____

Employer: _____

Who has legal guardianship of your child? _____

Please describe custody and the child's current living arrangements: _____

Is there any legal involvement with your child? Yes No If so, please describe: _____

Please bring copies of any court orders that impact your child.

Who are your child's significant others living with your child? Please list their names, ages, relationships, grades, and jobs if applicable:

1. _____

2. _____

3. _____

4. _____

Who are your child's significant others *not* living with your child? Please list their names, ages, relationships, grades, and jobs if applicable:

1. _____

2. _____

3. _____

4. _____

Intake Form for Child/Adolescent Psychotherapy (Page 2 of 2)

Child's name: _____ DOB/Age: _____ / _____

School attending and grade level (if applicable): _____

Child's job and employer (if applicable): _____

Work phone: _____ Work days and hours: _____

How were you referred: _____

Reason(s) for seeking therapy: _____

What goals do you have for therapy? _____

Have you sought mental health treatment before for your child? ___ Yes ___ No

If so, when and with whom? _____

Current medical doctor/Family physician: _____

Phone number: _____

Current medications (type and dosage): _____

Has there been any history or suspicion of physical, sexual, or emotional abuse? (If so please explain)

Have there been any suicide attempts? (If so, explain) _____

In case of emergency, please notify:

Name: _____ Phone: _____ Relationship: _____

Insurance (The following questions are about the policy holder.)

Policyholder's name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____

Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Insurance company: 1. (*Medical*) _____

2. (*Mental health*): _____

Authorization #: _____ Number of sessions authorized: _____ Co-pay: _____

Employer: _____

Job title: _____

If you are a dependent, what is your relationship to the policyholder: _____

By completing this form, my signature indicates that the information provided is truthful and accurate.

Form completed by: _____ Date: _____

Signature: _____

EMDR Client History and Treatment Planning Form

(This form is completed in addition to the clinician's standard intake form.)

1. What are the parent's current concerns and goals for treatment? (*"I know my child will have been successful in treatment when_____."*)

2. Themes: (What themes are presented by child/parent related to responsibility, safety, control/choice?)

3. Symptom Assessment: (Does child/parent have any indication as to precursor of symptoms? How long have symptoms been present? Are there any times when symptom(s) are not present?)

EMDR Client History and Treatment Planning Form (Page 3 of 3)

6. Identify mastery experiences presented by the child. (“Tell me something that you are proud of that you have done. Tell me a time when you felt really good about yourself.”)

Notes:

Clinician's name: _____ Date: _____

Clinician's signature: _____

Child Interview Questions

Child's name: _____ Date: _____

These questions are used to gather information from the child and build rapport in the therapeutic relationship. These questions can be used any time during the intake process. Any of the child's answers can be possible resources or targets for treatment.

1. Do you go to school? What school do you go to?
2. What's your teacher's name?
3. What is your favorite subject in school besides recess and lunch?
4. If you had three wishes, what would they be?
5. What's your favorite color?
6. If you ruled the world, what would be two things you would change right away?
7. What's your favorite television program?
8. What makes you laugh?
9. What's your favorite sport or activity?
10. Tell me something that makes you sad.
11. What's your favorite animal?
12. Who lives at your house? (Explore people and pets.)
13. Who is your favorite superhero/heroine? (Possible resource)
14. Ask children about their bedroom. Who shares your room? Who decorated your room? What's your favorite thing in your room? (This question gets at information about the child's position in the family. Who makes decisions in the family? Is the child allowed to make decisions about their own room or did a parent decorate the room and did the child have any input?)

Child Interview Questions (Page 2 of 2)

Child's name: _____ Date: _____

1. What's your favorite movie? What's your favorite video game?

2. What do you do when you get really upset? Do you go to your room? Do you ride your bike or play video games or watch television?

3. Do you like to listen to music? What songs do you like the most? Do you ever listen to music when you're happy or upset?

4. Tell me something that is annoying to you. (If the child is someone who is bothered by tags, etc., this question may be more expansive.)

5. Who do you talk to when you're upset?

6. Who are your best buddies? What do you guys like to do together?

7. What do you do at recess?

8. Do you ever have headaches or stomach aches?

Therapist's notes:

Therapist's signature: _____ Date: _____

Consent for Treatment of Minor/Child Assent Form

Consent for Treatment of Minor

This is an authorization for _____ (therapist name) to provide treatment and/or diagnostic services to my child/adolescent, _____ (name). By signing this Consent for Treatment, I certify that I legally have custody or joint custody of my son or daughter and, thus, can legally consent for treatment of my child.

Parent/Guardian Signature

Date

Child Assent Form

I understand that my parent or guardian may consent for my treatment; however, I have also been asked to give my assent for my own treatment. By signing below, I realize that the therapist listed above has elicited my own assent for treatment.

Child's name

Birth date

Sign your name here

Witness

Treatment Plan (Page 2 of 2)

Client name: _____

Date: _____

Client ID #: _____

Therapist: _____

Mode of treatment

Individual Group Parent/Child dyad

Assessment

Court-ordered Family Supervised visit

Frequency of Treatment _____

Treatment Methodology

Anger Management Conflict Resolution

Problem-Solving Skills Art Therapy

Desensitization Psychoeducational

Assertiveness Training Feeling Identification

Relaxation/Stress Mgmt Assessment

Grief Work Safety Planning

Behavior Modification Insight Oriented

Sand Tray Play Therapy

Bonding/Attachment Music Therapy

Trauma Focused EMDR

Parent Training Communication Skills

Other _____

Client/Legal guardian signature

Date

Therapist signature

Date

Date of review _____

(6 months from client signature)

Child/Adolescent Symptom Monitoring Form

Date: _____ Child's Name: _____

Parent Completing Form: _____

Therapist: _____

| Symptoms | Day by Day (Following Therapy) | | | | | | |
|--------------------------|--------------------------------|-------|-------|-------|-------|-------|-------|
| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| Stomach aches | | | | | | | |
| Diarrhea/Constipation | | | | | | | |
| Sleep Disturbance | | | | | | | |
| Behavioral Problems | | | | | | | |
| Tantrums/Acting Out | | | | | | | |
| Crying | | | | | | | |
| Avoidance Behaviors | | | | | | | |
| Agitation | | | | | | | |
| Urination/Bowel Problems | | | | | | | |
| Refusal Behavior | | | | | | | |
| Anxiety | | | | | | | |
| Change in eating habits | | | | | | | |
| Headaches | | | | | | | |

Note: 1 = minimal, 2 = moderate, 3 = severe

Other symptoms possibly related to treatment:

| Symptoms | Day by Day | | | | | | |
|----------|------------|-------|-------|-------|-------|-------|-------|
| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Note: 1 = minimal, 2 = moderate, 3 = severe

Additional Comments/Concerns:

Please complete this form and bring it to your child's next session. Thank you!

EMDR Progress Note

(This progress note is utilized after intake when Client History and Treatment Planning is completed, for initial or subsequent sessions starting with the Preparation Phase of EMDR.)

Review the developments since the last session (affective, somatic, cognitive, behavioral, imagery, symptoms, environmental changes. Therapist makes notes of any new concerns or changes in the child's life).

Preparation: (What skills/resources does the child have and what skills/resources does the child need to continue with the EMDR protocol?)

Following the Targeting Sequence Identified as part of Client History and Treatment Planning or if the therapist previously started Assessment and Desensitization of targets.

SUD on previous session's target (0-10) (Note particular type of measurement used by the child.):

VoC on previous session's positive cognition (1-7) (Note particular type of measurement used by the child.):

Body scan on previous session's target (Note location of any negative or positive body sensations reported.)

EMDR Progress Note (Page 2 of 4)

Target Identification

Memory/Target for current session (target from previous session/new target):

Assessment

Picture:

Negative cognition:

Desired positive cognition:

VoC: 1 2 3 4 5 6 7
(completely false) (completely true)

Client: _____ Therapist: _____

Date: _____ Visit: _____

EMDR Progress Note (Page 3 of 4)

Emotions

SUD

0 1 2 3 4 5 6 7 8 9 10
Neutral, no disturbance Worst disturbance

Body sensations (location and description)

Resources

Resources used:

Closure

SUD at end of session (0-10):

VoC (if applicable) at end of session (1-7):

Body scan (Note location of any negative or positive body scan reported.)

Completed session: YES NO

Closure exercise used (i.e. Safe/Calm Place, Relaxation Exercise, Containers):

Additional notes attached? YES NO

Form for Safe/Calm Place:

Safe/Calm Place Worksheet

Image: _____

Positive emotions: _____

Physical sensations (location and description): _____

Cue word(s): _____

Minor disturbance for cuing/self-cuing practice: _____

Safe/Calm Place Protocol Abbreviated Instructions Form

Step 1: Describe image.

Step 2: Describe emotions and positive sensations (including location).

Step 3: Enhance imagery and affect with soothing tones.

Step 4: Introduce short sets of BLS (2–4 saccades).

If positive outcome, continue with several more short sets.

If minimal or neutral outcome, try alternative direction of BLS.

If intrusions or negative response, explore solutions (e.g., containment of negative material, add more protective features to Safe/Calm Place) or switch to a different Safe/Calm Place or comforting resource image.

Step 5: Identify cue word(s). Guide the child in holding cue word(s) and Safe/Calm Place together as several sets of BLS are added.

Step 6: Have the child practice self-cuing, focusing on image and word(s) without BLS.

Step 7: Have the child bring up a minor disturbance. The therapist cues the Safe/Calm Place.

Step 8: Have the child bring up a minor disturbance. The child cues the Safe/Calm Place.

RDI Worksheet—Part 1

Needed resources (qualities, capacities, strengths, needs, feelings, beliefs as identified by client): _____

Resource Development

Mastery experiences and images: _____

Relational resources: _____

Metaphors and symbols: _____

Clinician's Signature: _____ Date: _____

After completing this worksheet, the therapist needs to consider the child's needs for further developing the resource. If so, continue with the next section.

RDI Worksheet—Part 2

Needed resource (quality, capacity, strength, need, feeling, belief as identified by client): _____

Resource target selected (e.g., mastery experience or image, supportive person, metaphor, or symbol):

Image: _____

Additional details (sounds, smells, textures, etc.): _____

Positive emotions: _____

Positive physical sensations (location and description): _____

Associated positive cue words: _____

What strengthens the client's connection to the resource (i.e., hearing words of encouragement from a supportive person, holding the resource in their hands, moving closer to the resource)?

Clinician's Signature: _____ Date: _____

EMDR Fidelity Questionnaire

Phase 1: Client History and Treatment Planning

Did you identify a client history and treatment planning process? YES NO

Phase 2: Preparation

Did you identify aspects of the therapist preparing the client for additional phases of the EMDR protocol? YES NO

Phase 3: Assessment

Did you identify aspects of the therapist conducting assessment of the client in anticipation of proceeding with Phase 4 Desensitization? YES NO

Did the therapist identify a specific memory or picture and then identify the worst part? YES NO

If yes, please describe the target. _____

Did you identify a NC? YES NO

If yes, please describe the NC. _____

Did you identify a PC? YES NO

If yes, please describe the PC. _____

Did you identify a VoC? YES NO

If yes, what was the initial VoC? _____

Did you identify an emotion? YES NO

If yes, what was the emotion identified? _____

Did the therapist get a SUD? _____ YES NO

Did you identify a body sensation? YES NO

If yes, what body sensation was identified? _____

Phase 4: Desensitization

Did the therapist desensitize the target to SUD of 0 and VoC of 7? YES NO

If no, did the therapist proceed with desensitization and process an incomplete session? YES NO NA

Phase 5: Installation

Did you identify the therapist utilizing an installation process? YES NO

Phase 6: Body Scan

Did you identify the therapist proceeding with the body scan process? YES NO

EMDR Fidelity Questionnaire (Page 2 of 2)

Phase 7: Closure

Did you identify the therapist implementing a closure process?

YES NO

Phase 8: Reevaluation

At some point in the client's treatment, did you identify a reevaluation process utilized with the client? YES NO

Three-pronged protocol:

1. Was there evidence that the therapist assessed processing in the present?

YES NO

2. Was there evidence that the therapist assessed processing in the present?

YES NO

3. Was there evidence of the therapist's application of Future Template by guiding the client through application of new skills to a future event? YES NO