Radical Solutions Therapy Services

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INTAKE FORM Date_____

Parents Information

Last name:_____

First Name:_____

Spouse last name:_____

Spouse first name_____

Current address_____

Mailing address if different_____

Occupation_____

Education Level _____

Have you or your spouse ever been in therapy before? Yes No

Briefly explain reason_____

Was your experience helpful? Yes No

Briefly explain reason_____

Do you or your spouse take any medications of any type for any reason?

_____

_____

_____

_____

How would you categorize your current physical health?

Good Bad Average Spouse Good Bad Average

Do you (or spouse) have any biological family history of mental illness? Yes No

List diagnosis and relationship

_____

_____

_____

_____

_____

Have you or your spouse experienced abuse or neglect as a child? Yes No

Briefly explain_____

Have you or your spouse experienced any type of trauma? Yes No

Briefly explain

_____

_____

_____

_____

_____

How would you describe your relationship with your parents?

_____

_____

_____

_____

How would your spouse describe their relationship with their parents?

_____

_____

_____

_____

How would you explain your parenting style? Authoritarian/ Disciplinarian Permissive

Authoritative Uninvolved Balanced

Do you use rewards and or punishments to correct your child's behavior? Yes No

How would you describe your attachment style? Secure in that you can effectively communicate and be vulnerable in your relationships with others?

Yes NO Spouse Yes No

Fearful/Avoidant in that you switch from feeling hot and cold towards your relationships and find yourself confused at times about how you feel about loved ones? Yes NO Spouse Yes No

Anxious/Preoccupied in that you find your loved ones often pull away from you?

Yes NO Spouse Yes NO

Dismissive/ Avoidant in that you struggle with expressing vulnerability and often struggle with communication in your relationships?

Yes NO Spouse Yes NO

What is the state of your marital relationship at the current time as it related to the struggle your currently facing?

Supportive/ Connected?

Strained/ conflicted?

Unsure/ Ambivalent?

What specific goal would you and your spouse like to work on as a priority?

_____
_____
_____
_____
_____
_____
_____

Are you committed to engaging in the learning process required to succeed? This might involve watching videos and reading materials related to Reactive Attachment Disorder, and other relevant information as well as Communication Strategies and some simple homework to complete between sessions. Your commitment makes a great deal of impact on your success.

Yes Not sure No Spouse Yes Not sure No

Radical Solutions Therapy Services has a 48-hour cancelation policy that requires full fee payment for missed appointments. We set aside special time just for you and we cannot fill your spot with less than 48-hour notice. Life happens and sometimes we cannot control things like sudden illness, flat tires, car accidents, or severe weather, and we understand this. We require a credit card to remain on file for last minute cancelations. We keep all information in a locked file cabinet for your protection. By signing this form, you agree to this policy.

Signature_____

Card # _____

Expiration Date _____month _____year CV code _____Billing Zip_____

Having a family/friend support system has been shown to increase your success, but many families often struggle finding supportive help. Do you have any family/friends who are interested in being supportive and who are interested in meeting with us to learn how to best support you during this time? Yes No Not Sure

Now About the Child or Children

Last Name_____

First Name(s)_____

_____

_____

Date of Birth_____

List all siblings first names and ages if they are living in the home_____

_____

_____

_____

_____

List all medications that the child is currently taking_____

_____

_____

_____

Who is the Psychiatrist?_____

_____

_____

Have they recently had a medical check-up? Yes No

Who is the Pediatrician?

_____

_____

Do you agree to allow collaboration between the Dr's and the Therapist for the treatment planning for your child? Yes No

Signing here gives consent for releasing information for the purpose of collaborative treatment planning for child.
Signature_____date _____

Is your child adopted? Yes No Are you biologically related? Yes NO

Was the child adopted from the foster system? Yes No

Were you the foster parent? Yes NO

How old was the child at the time they came into your care permanently? _____

How many placements has this child experienced? _____

Can you provide any assessment documents if any related to the child's previous mental health treatment or any pediatrician's assessments? Attach to this form a copy of any documents

What specific information have you been given about this child's trauma/ neglect history prior to fostering/ adopting?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Describe the most difficult behavior issues you observe in your child._____

_____

_____

_____

_____

_____

_____

Briefly describe any strategies you have tried so far to help your child and if they worked.

Have you read any books or watched any video's about childhood trauma/neglect and its impact on development? Yes No

If Yes list them here

Have you taken this child to therapy before? Yes NO

If Yes briefly describe the type of treatment

Was this treatment helpful? Yes No

Briefly describe the positives and negatives of the experience.

What is your child's favorite pass time? Toy or game?

Does your child have an individual education plan? Yes NO

Describe

Has your child had a neuropsychological examination? Yes No Attach report if yes

Does your child struggle in school? Yes No

What is their typical average grade report ? A B C D F or do they have

highs and lows such as A's and D/F"s Yes No

Is your child learning via internet physical classroom? homeschool

What grade are they in? _____

Were they ever held back a grade? Yes No

How well does your child sleep? Good Fair Not well Wakes up often Sleeps Alone

Never Sleeps Alone Nightmares Wets the Bed Tossing /Turning a lot

How well does your child eat? Good Fair Picky

Only likes the yellow food groups? Yes No

Tries new foods: often seldom never

Eats too much like there is no off switch? Yes No

Eats too little like there is no appetite? Yes No

Seeks sugar above everything else? Yes No

Has your child ever been baker acted? Yes No

If yes explain when and
why?_____
_____
_____

Has your child ever expressed suicidal thoughts? Yes NO

Describe
_____
_____
_____
_____

Does your child have friend's Yes No how many? _____ Ages ?_____

Does your child know why they are coming to therapy? Yes NO

What ways to you feel you are contributing to the challenges your facing at the current time?

_____
_____
_____
_____

What do you consider your strengths and weaknesses as a parent in relationship to this child?_____
_____
_____
_____
_____

Does this child get physically aggressive toward any family member? Yes No

Briefly describe

_____
_____
_____

Has this child ever been in trouble with the authorities? Yes No

Briefly describe_____
_____

What goals would you most like your child to achieve for your child's future?_____
_____
_____
_____

Is there anything else you would like to say that could be helpful or important?_____
_____
_____

We welcome you to the journey of connecting with your child in a deeper way. We know how challenging it can be living with the ups and downs parents face as they navigate Reactive Attachment Disorder. Stay on the road and it will take you to a better place. Some days you may feel victorious and other days like giving up. Be kind to yourself and take things a day at a time. We are here to support you on this journey. We provide text access 24/7. You are permitted to text any time however we might not answer immediately. You are welcome to email anytime with questions, concerns, or simply to express your frustration and to celebrate your victories along the way.