Santa Rosa Health Collective
1008 Fifth Street
Santa Rosa, CA 95404
(707)529-3030 Cell
(707)708-8504 Fax
drlucasplumb@gmail.com

Minor Intake Information

Lucas Plumb, PhD, PSY 24405

"Tell me, what is it that you plan to do with your one wild and precious life?" -Mary Oliver

One parent must accompany child to the first session. When you answer the following questions, please be as complete as possible so that Dr. Plumb can learn important things about yourchild, and refer back to thisinformation throughout our thetherapy..

Today's Date_____

Child's Legal Name_____ Age _____DOB_____

Child's Present Address _____Does child live here full time? _____

City / State / Zip _____ Cell Phone (_____)_____

Parents Names _____ Child's Gender M F T Fluid

Child's School or Daycare _____ Phone _____

Emergency Contact _____ Phone_____

Most recent year of school completed _____Where_____ Date _____

Insurance Carrier _____ ID # _____

What are the main concerns about your child that you wish to address? _____

_____

_____

If you and your partner are separated, please answer the following questions:

Custodial Parent _____ Joint or Sole Custody _____

Responsible Parent's Name _____

Non-Custodial Parent's Name _____Phone #_____

Address_____ City/State/Zip_____ _____

What is the nature of the relationship with the non-custodial parent? _____

Does the non-custodial parent know that their child is going to enter therapy? _____

_____

If there is a custody agreement, please provide a copy of it. _____YES _____NO _____DATE

Which other adults are living with/raising your child?_____

I live with my child's other parent_____ I am currently separated from my child's other parent_____

I am living with a partner who is my child's step-parent_____ I am living alone with my child._____

I have _____% custody at this time. I am satisfied with that_____ I am not satisfied with that _____

Describe your feelings toward your partner [whether you are with your child's father or with a new partner]:

_____

Describe your relationship with your child_____

_____

How do you think your child would describe you?_____

_____

How do you think your child feels about the relationship between you and your partner?_____

_____

How would you describe your child's birth? _____

_____

Siblings/Ages _____

Describe your child's relationship with their siblings _____

_____

Has your child reported having any suicidal or homicidal thoughts? Please don't minimize this question____

_____

Past or present medications for psychological conditions:

MEDICATION	DOSAGE	DATE STARTED/ENDED	PRESCRIBING PHYSICIAN

Are you aware of any history of mental illness, alcoholism, or drug abuse in your extended family?

_____

_____

Have you or your child ever been affected by or had difficulty with alcohol or recreational drugs? Describe.

_____

Has your child suddenly started having difficulty at home or school or with friends? _____ Describe _____

_____

Are guns kept in your home? _____ Do you feel your children are safe? _____

Please describe your child's state of physical health and any problems they may have at this time _____

_____

_____

Are they under a physician's care? Yes ____ No ____ Name of Physician _____

Do you utilize nutrition to improve your child's health & well-being?_____

_____

Whom may I thank for referring you _____

What does your family do to sustain itself in stressful situations? _____

_____

What spiritual interests and practices does your family currently have? _____

_____

What was the one most important factor that made you decide to contact me at this particular point?

_____

_____

If you were to imagine an ideal outcome to my work with your child, how would you describe what

it would look like _____

_____

_____

Please feel free to add anything else that you would like me to know about your child._____

_____

_____

Thank you very much--I look forward to our work together!

Client Agreement

I, _____ understand that in entering into a therapeutic relationship with Lucas Plumb, PhD, I and my child have the absolute right to confidentiality in my therapy, and she is bound by professional ethics which require strict confidentiality in the treatment of all information. Dr. Plumb will not tell anyone else what I have told her, or even that I am in therapy with her unless I give my prior written permission; Dr. Plumb can only release information when I sign a consent form allowing it. The only exceptions to this are if Dr. Plumb believes I am in imminent danger of harming myself or I might seriously harm another person, or if I reveal that I am abusing a child or elder adult (age 65 or over). In those cases she is a mandated reporter, but she will make every attempt to talk these issues over with me should they arise.

I understand that it works better to pay my fee to Dr. Plumb at the time of service, and I will not be allowed to get behind more than two appointments with my balance. There will be a $20 fee for returned checks.

I understand that if a third party such as an insurance company is paying for part of my bill, Dr. Plumb is normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of my issues and something about whether they are short-term or long-term problems. If I do require a diagnosis, Dr. Plumb will discuss it with me fully.

I understand that Dr Plumb has set aside this time for my child's therapy, and that I am responsible for keeping my appointment. If I do not cancel with 24 hours notice, I will pay for the session.

I understand that therapy always has potential emotional risks. Approaching feelings or thoughts that one has tried not to feel or think about for a long time may be painful. Making changes in one's beliefs or behaviors can be difficult and sometimes disruptive to the relationships one already has. I have considered carefully whether these risks are worth the benefits of changing.

I understand that Dr. Plumb will need to charge for phone calls and emails after 5 minutes.

I understand that Dr. Plumb is always willing to discuss how and why she has decided to work in certain ways with me and my child as well as to look at alternatives that might work better. I know that I have the right to ask questions about anything that happens in therapy. I understand that I can feel free to ask her to try something that I think will be helpful for me and my child. I can also ask her about her training for working with my concerns, and can request that she refer me to someone else if I decide she is not the right therapist for me or my child. In understand that I am free to end therapy at any time, but if I decide to discontinue therapy, that I will schedule at least one session for closure.

I understand that Dr. Plumb cannot provide letters or evaluations in legal or other matters around legal issues.

I understand that if my child is in crisis and we cannot reach Dr. Plumb, I am to call Sonoma County Emergency Mental Health Hotline at (800)746-8181, or the North Bay Suicide Prevention Hotline (855)587-6373; if that is not adequate support, I agree to go to my preferred emergency facility or call 911.

DATE: _____ SIGNATURE _____ PRINTED _____