Soha Dardashti, LMFT 86064

1355 Westwood Blvd., #9

Los Angeles CA 90024

Tel: (310) 592-5921

Child and Adolescent Intake

Parents or Legal Guardians: Please fill out this form, providing your child's information.

First Name: _____ Last name: _____

Gender: _____ Today's date: _____

Date of Birth: _____

Client's home address: _____

Mother's First Name: _____ Mother's maiden Name: _____

Mother's Age: _____ Mother's age at client's birth: _____

Mother's Occupation: _____

Mother's home address: _____

Mother's phone number: _____

Mother's Marital Status: (Name of Spouse if applicable) _____

Father's First Name: _____ Father's Last Name: _____

Father's Age: _____ Father's age at client's birth: _____

Father's Occupation: _____

Father's home address: _____

Father's phone number: _____

Father's Marital Status: (Name of Spouse if applicable)

Client's siblings/names/age:

Reasons for seeking counseling:

Your child's current symptoms and behaviors that led you to seek counseling:

Describe onset and frequency of symptoms:

In your opinion what are the contributing factors to your child's symptoms:

Please circle if your child is displaying any of the below symptoms:

Anxiety Depression Difficulty with sleep Issues at school Change in appetite

School performance Issues with peers at school Issues with siblings shyness

Difficulty following instructions at Home/ school Anger Tantrums Defiance

Mood changes Changes in Hygiene

If you circle any of the above, please describe in the space bellow

In your own words describe what do you expect to achieve in counseling for your child.

Medical History:

1. Is your child currently taking any medication? If yes please indicate name/dosage/diagnosis

2. Does your child have any chronic illnesses? If yes please indicate diagnosis and onset

3. Does your child have any allergies? If yes please list

4. Please list any history of Surgeries/ Hospitalization or indicate none.

5. Please list any medical history for client's parents, siblings, extended family members.

Educational History:

1. Client's school Name:
2. Client's current educational level:
3. Has client ever been evaluated for any developmental disabilities?
4. Does client have any diagnosis of learning/academic disability?
5. Has client ever received an IEP?
6. What is client average academic performance grade?

Please indicate any other possible issues not mentioned above.

Substance Use screening and Assessment: (This section does not apply to younger children)

1. During the past 12 months did you drink any alcohol?
2. During the past 12 months did you smoke any marijuana?
3. During the past 12 months did you use anything to get high?

History of Suicidality:

Has your child ever disclosed thought/plans/intentions of hurting /killing themselves?

Family History of Mental Illness:

Please list if anyone in client's family (both maternal and paternal side) has ever gotten a diagnosis of a mental illness.

History of Trauma or exposure to Trauma:

Has your child ever experienced a trauma? If yes please describe

Client's current living arrangement:

Does client currently live with both biological parents?

If you answered No please describe the living/custodial arrangement.

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Informed Consent for treatment:

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information About Your Therapist:

Soha Dardashti is a Licensed Marriage Family Therapist (LMFT 86064). Soha Dardashti earned her Master of Science in Psychological Counseling with emphasis on Marriage Family Therapy from California State University of Northridge with Distinction in 2008.

Fees and Insurance:

Sessions are approximately 50 minutes in length

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

Fee per session agreed with client and therapist prior to first session is **$**.

Confidentiality:

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family

therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to her by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.

Please feel free to ask your therapist about her "no secrets" policy and how it may apply to you.

Minors and Confidentiality:

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies:

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours' notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Communication with Therapist:

You are always welcomed to call your therapist and leave a message to be contacted. Please allow approximately 12 hours for therapist to call back. Please refrain from sending text messages/emails to your therapist containing confidential information. Soha Dardashti will not send you text/emails discussing clinical/confidential matters.

About the Therapy Process:

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy:

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents, (giving consent for treatment of your minor child/yourself) as it applies to Soha Dardashti. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Name of Client (please print)

Name of Custodial parent (If client is under 18 years of age)

Signature of Client

Signature of Parent (if client is under 18 years of age) **Today's date**