



Santa Rosa
Health Collective

1008 Fifth Street
Santa Rosa, CA 95404
(707)529-3030
nlplumb@sonic.net

Minor Intake Information

Lucas Plumb, PhD, PSY 21105

“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 you and refer back to this information throughout our work together.

Today's Date _____

Child's Legal Name _____ Age _____ DOB _____

Child's Present Address _____ Social Security # _____

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 _____

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? _____

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

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

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 _____

Please answer the following questions whether you are with your current partner or separated:

Describe your feelings toward your 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 his/her siblings _____

Has your child reported having any suicidal thoughts? _____

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 ever been affected by or had difficulty with alcohol or recreational drugs? ____ Please describe

Have you told your partner that you are bringing your child to therapy? _____ If not, why _____

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

Are she/he 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 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 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 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. 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. I understand that I am free to leave 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 _____