Patient’s Initials: \_\_\_\_\_\_\_\_\_\_\_ Patient’s Age: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist first name and last initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Directions:** Please complete the following page of questions about your child intake and submit at disposition with Diana.

1. Please list three treatment goals you have for the upcoming work that your child patient and his/her therapist will engage in:
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Check the appropriate box to indicate the recommendation for the child’s treatment:

* The child will continue treatment with you (the intake therapist)
* The child will be transferred to another therapist at the Psychological Center
* The child will be referred out

1. On a scale of 1 to 5, how would you rate the following:
2. The difficulty level of getting your child patient’s primary caregiver to schedule and attend appointments.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Easy to engage | 1 | 2 | 3 | 4 | 5 | Difficult to engage |

1. The level of effort your child patient’s primary caregiver has made to attend collateral sessions.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Makes a concerted effort | 1 | 2 | 3 | 4 | 5 | Generally resists involvement |

1. The overall engagement of your child patient’s primary caregiver in the intake.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Generally engaged | 1 | 2 | 3 | 4 | 5 | Overall lack of engagement |