Welcome to Forster Counseling LLC. Please note that this information is important for your care. The information you provide here is protected as confidential information. Please fill out forms as completely as possible and have them ready before your first counseling session.

CHILD INTAKE FORM (TO AGE 11)

For Parent/Guardian to Complete

Child's Name: _____ DOB:_____ Age: _____

Address: _____

School: _____Grade: _____

Race/Ethnic Origin: _____ Religious Preference: _____

How did you hear about our office? _____

(this is for my tracking purposes only. In order to preserve confidentiality, I will not contact them.

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

PARENT'S HISTORY

PARENT'S MARITAL STATUS *(this question refers to the biological parents' relationship)*

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed

❒ Other Length of marriage/relationship: _____

If divorced, how old was your child at time of divorce? _____

If divorced, how much time does your child spend with each parent? Mother_____% Father _____%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Biological Father's Name: _____Birth Date: _____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? ❒ Yes ❒ No Combat experience? ❒ Yes ❒ No

Current Status _____Single ____Married ____Divorced ____Separated _____Widowed _____Other

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Biological Mother's Name: _____Birth Date: _____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? ❒ Yes ❒ No Combat experience? ❒ Yes ❒ No

Current Status _____Single ____Married ____Divorced ____Separated _____Widowed _____Other

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Problem Description (Please state the problems for which you want help for this child:)

_____

_____

_____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? ❒ Yes ❒ No
   If yes, describe: _____
2. Did your child have health problems at birth? ❒ Yes ❒ No
   If yes, describe: _____
3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
   ❒ Yes ❒ No ❒ Not sure If yes, describe: _____
4. Did your child have any unusual behaviors or problems prior to age 3? ❒ Yes ❒ No ❒ Not sure
   If yes, describe: _____
5. Has your child experienced emotional, physical, or sexual abuse?
   ❒ Yes ❒ No ❒ Not sure If yes, describe: _____

_____

Emotional/Behavioral/Chemical Issues *(Has your child recently or currently experienced the following?)*

CONCERN	YES	NO	CONCERN	YES	NO
Recent Suicidal thoughts			Difficulty sleeping		
Suicide plans			Depression,		
Suicide attempts			Loneliness, or hopelessness		
Self-inflicted injury behaviors			Crying often		
A tendency to be shy or sensitive			Frightening dreams or thoughts		
A strong dislike of criticism			Often annoyed by little things		
A frequent loss of temper			Difficulty completing tasks		
Difficulty expressing feelings			Violent or destructive behavior		
Nervousness, anxiety, or worry			Difficulty remembering		
Difficulty relaxing			Difficulty concentrating		
Difficulty making decisions			Mental Confusion		
Difficulty making friends			Difficulty with eating		
Irritability			Lying		
School/Academic problems			Thoughts of hurting others		
Compulsive behavior			Peer/sibling conflict		

Has your child ever been in court or picked up by the police? ❒ Yes ❒ No

If yes, describe: _____

Do you think your child has tried cigarettes, sniffing, vaping, alcohol or drugs? ❒ Yes ❒ No

If yes, describe: _____

Does your child have a cell phone? ❒ Yes ❒ No

How many hours of screen time *(computer, video games, TV)* does your child engage in daily? _____

PEER RELATIONS

1. Is your child socially: ___outgoing ____shy ____depends on the situation.

2. Has your child experienced any bullying? ❒ Yes ❒ No

2. Is your child involved in any organized social activities (e.g. sports, scouts, music)? ❒ Yes ❒ No

List activities_____

SCHOOL HISTORY

1. Has your child ever been held back a grade? ❒ Yes ❒ No If yes, what grade and what was the reason you choose to hold your child back: _____
2. What are the grades your child receives at school? _____
3. Do you feel your child is doing the best he/she can at school? ❒ Yes ❒ No
4. Are there any behavior problems at school? ❒ Yes ❒ No

   If yes, please explain: _____
5. How many schools has your child attended? _____

DISCIPLINE

Are there any concerns in regard to discipline? ❒ Yes ❒ No If yes, please explain: _____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? ❒ Yes ❒ No

If yes, please explain your concern: _____

COUNSELING HISTORY

Has your son or daughter previously seen a counselor? ❒ Yes ❒ No

If Yes, where: _____

Approximate dates of counseling: _____

For what reason did your son or daughter go to counseling? _____

Does your son or daughter have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy? _____

What did you find **least helpful** in therapy? _____

Has your son or daughter used psychiatric services? ❒ Yes ❒ No

If yes, who did they see? _____

If yes, was it helpful? ❒ Yes ❒ No

Has your son or daughter taken medication for a mental health concern? ❒ Yes ❒ No

Name of medication	Dates taken	Was it helpful? Y/N

HEALTH CONCERNS:

1. In general, this child's heath has been:

_____ excellent (is rarely sick, when sick recovers very quickly)

_____ good (is not often sick or injured, illnesses are fairly short-lived)

_____ fair (frequently sick or injured, illnesses often linger or recur)

_____ poor (chronically ill)

2. Name of physician: _____

3. Name of clinic: _____

4. Medications: _____

5. Does your son or daughter have other medical concerns or previous hospitalizations? ❒ Yes ❒ No

If so, please describe. _____

6. Inherited conditions (e.g. Huntington's Chorea, Sickle Cell Anemia): _____

_____

FAMILY ILLNESSES/DISORDERS

	Mother's Family	Biological Mother	Biological Father	Father's Family
Anxiety disorders				
ADHD or ADD				
Mental retardation				
Seizure disorder				
Depression				
Schizophrenia				
Other psychiatric disorder				
Learning difficulties				
Behavioral problems				
Alcoholism or drug dependence				
Difficulty with anger/losing temper easily				

CHILD'S STRENGTHS *(Please mark those strengths that you have observed in your child):*

	Often True	**Sometimes True**	**Seldom True**	**Cannot Say**
Outgoing				
Self-confident				
Seems happy				
Friendly				
Enjoys new experiences or activities				
Even disposition or steady moods				
Expresses feelings				
Affectionate				
Kind or sympathetic to others				
Shares				
Can compromise				
Follows rules easily				
Is forgiving				
Stands up for self when appropriate				
Tolerates criticism				
Recovers easily after disappointment				
Is appropriately cautious				
Creative				
Plays gently with smaller children or animals				
Good sense of humor				
Other…				

Is there anything else you would like me to know? _____

_____

_____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

SIGNATURE_____ DATE_____