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.

ADOLESCENT INTAKE FORM (ages 12-17)

Adolescent please fill out pages 1-3, Parent/guardian please fill out pages 4-8

CLIENT INFORMATION

Name: _____ Address: _____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female

Phone (Cell): _____ Messages okay? _____ Text reminder okay? ❒ Yes ❒ No

Email: _____ Email okay? ❒ Yes ❒ No

School: _____ Grade: _____

Please share electronic communication (Facebook, Twitter, SnapChat, Instagram, etc) that you use:

_____

Do your parents have access to your electronic communication? ❒ Yes ❒ No Do they have any issues with your use of phone, text, electronic communication? ❒ Yes ❒ No

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful at when you try? _____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem you are seeking counseling for: _____

_____

What would you like to see happen as a result of counseling? _____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No

If yes, what did you find **most helpful** in therapy? _____

_____

If yes, what did you find **least helpful** in therapy? _____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? ❒ Yes ❒ No

If yes, how often do you drink? ❒ Daily ❒Weekly ❒Occasionally ❒Rarely

If yes, how much do you drink? _____ (#) per time.

Do you currently use Tobacco? ❒ Yes ❒ No

If yes, how much do you smoke/chew/vape? _____

Do you currently use any other drugs? ❒ Yes ❒ No. If yes, what drugs _____

If yes, how often do you use? ❒ Daily ❒Weekly ❒Occasionally ❒Rarely

Have you received any previous treatment for chemical use? ❒ Yes ❒ No

If so, where did you go? _____ ❒ Inpatient ❒ Outpatient

Adolescents

1. Have you ever used more than 1 chemical at the same time to get high? ❒ Yes ❒ No
2. Do you avoid family activities so you can use? ❒ Yes ❒ No
3. Do you have a group of friends who also use? ❒ Yes ❒ No
4. Do you use to improve your emotions such as when you feel sad or depressed? ❒ Yes ❒ No

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present or have had a significant effect upon you in the past. _____

_____

FAMILY HISTORY

1. Are your parents married or divorced? _____
2. Do you think their relationship is good? ❒ Yes ❒ No _____
3. If your parents are divorced, who do you primarily live with? _____
4. How often do you see each parent? Mom_____% Dad _____%.
5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? ❒ Yes ❒ No Please describe as much as you feel comfortable. _____

_____

_____

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

Other concerns not listed above _____

PEER RELATIONS

1. How do you consider yourself socially: ___outgoing ____ shy ____ depends on the situation.
2. Are you happy with the number of friends you have? ❒ Yes ❒ No
3. Have you ever been bullied? ❒ Yes ❒ No
4. Are your parents happy with your friends? ❒ Yes ❒ No
5. Are involved in any organized social activities (e.g. sports, scouts, music)? _____

SCHOOL HISTORY

1. Do you like school? ❒ Yes ❒ No _____
2. Do you attend regularly? ❒ Yes ❒ No _____
3. What are your current grades? _____
4. Do you feel you are doing the best you can at school? ❒ Yes ❒ No _____
5. Do you feel you are safe at school? ❒ Yes ❒ No _____

INDIVIDUAL CONCERNS

SYMPTOM	NONE	MILD	MOD	SEVERE		SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS						APPETITE CHANGES				
CRYING						SOCIAL ISOLATION				
SLEEP DISTRUBANCES						PARANOID THOUGHTS				
PROBLEMS AT HOME						POOR CONCENTRATION				
HYPERACTIVITY						INDECISIVENESS				
BINGING/PURGING						LOW ENERGY				
LONELINESS						EXCESSIVE WORRY				
UNRESOLVED GUILT						LOW SELF WORTH				
IRRITABILITY						ANGER ISSUES				
NAUSEA/INDIGESTION						SPIRITUAL CONCERNS				
SOCIAL ANXIETY						HALLUCINATIONS				
SELF MUTALATION						RACING THOUGHTS				
CUTTING						RESTLESSNESS				
IMPULSIVITY						DRUG USE				
NIGHTMARES						ALCOHOL USE				
HOPELESSNESS						EASILY DISTRACTED				
ELEVATED MOOD						TRAUMA FLASHBACKS				
MOOD SWINGS						OBSESSIVE THOUGHTS				
DISORGANIZED						PANIC ATTACKS				
ANOREXIA						FEELING ANXIOUS				
GRIEF						FEELING PANICKY				
PHOBIAS						SUICIDAL THOUGHTS				
HEADACHES						PAST SUICIDE ATTEMPTS				
WEIGHT CHANGES (*UNPLANNED CHANGES*)						OTHER				

***We would like you to know that we have worked with a lot of adolescents and that we respect your privacy and we hope to create an atmosphere where you feel comfortable sharing.**

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ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female

Race/Ethnic Origin: _____

Religious Preference: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

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

(If additional space is need please list on the back of page)

Current Reason for Seeking Counseling for Your Adolescent.

Briefly describe the problem for which your adolescent is seeking counseling for:

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

What is most concerning right now?

_____

_____

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 If yes, describe: _____
4. Did your child have any unusual behaviors or problems prior to age 3? ❒ Yes ❒ No. If yes, describe:

   _____
5. Has your child experienced emotional, physical, or sexual abuse?

   ❒ Yes ❒ No If yes, describe: _____

COUNSELING HISTORY

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

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)

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

If so, please describe. _____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? ❒ Yes ❒ No

If yes, please explain your concern: _____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

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

If yes, please explain your concern: _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____

_____

FAMILY HISTORY

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? ❒ Yes ❒ No Please describe as much as you feel comfortable. _____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? ❒ Yes ❒ No

_____

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: _____

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: _____

Current Status: ❒Single ❒Married ❒Divorced ❒Separated ❒Widowed ❒Other

Assessment of current relationship if applicable: ❒Poor ❒Fair ❒Good

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful at when they try? _____

_____

What personal qualities would you say your son or daughter has? _____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe) _____

_____

Is there anything else you would like to share: _____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

SYMPTOM	**NONE**	**MILD**	**MOD**	**SEVERE**	**SYMPTOM**	**NONE**	**MILD**	**MOD**	**SEVERE**
SADNESS					APPETITE CHANGES				
CRYING					WEIGHT CHANGES *(UNPLANNED CHANGES)*				
SLEEP DISTRUBANCES					PARANOID THOUGHTS				
DISSOCIATION					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/PURGING					LOW ENERGY				
FEELING ANXIOUS					EXCESSIVE WORRRY				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/INDIGESTION					SPIRITUAL CONCERNS				
SOCIAL ANXIETY					HALLUCINATIONS				
GRIEF					RACING THOUGHTS				
CUTTING					RESTLESSNESS				
IMPULSIVITY					DRUG USE				
NIGHTMARES					ALCOHOL USE				
HOPELESSNESS					HEADACHES				
LONELINESS					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					WORK ISSUES				
ANOREXIA					PROBLEMS AT HOME				
SOCIAL ISOLATION					PANIC ATTACKS				
PHOBIAS					SUICIDAL THOUGHTS				
OBSESSIVE THOUGHTS					PAST SUICIDE ATTEMPTS				

Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the doctor, counselor, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to Oregon law, and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children age 14 or older.
- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.

- You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.
- In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.
- Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

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_____