Monthly Contact Form for Children Receiving Mental Health/Behavioral Treatment

Child's name: _____ Head Start Classroom: _____

Counselor/Case Manager Name: _____

Date of Contact: Email/Call date: _____ Counselor responded on: _____
Left Voicemail: YES NO Date _____
2nd Attempt: _____

Phone # or email: _____

Family contact information up to date? _____

_____

Appointments:

Any appointments scheduled for this child? If so, when? _____

_____

Parent:

Family concerns? _____

_____

_____

_____

Student:

Student concerns? _____

_____

_____

_____

_____

We worked on these goals last month: _____

_____

_____

_____

_____

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What goal(s) are you focusing on this month? _____

_____

_____

_____

_____

Date of next phone call or email: _____

_____

_____

Notes for Family Service Specialist:

Any comments written in this section need to be shared with the FSS:

_____

_____

_____

_____