Family Intake Form

Parents:

Name: _____Date of Birth_____
(Last) (First) (Middle Initial)

Name: _____Date of Birth_____
(Last) (First) (Middle Initial)

Address: _____

_____

(Please circle preferred contact number.)

Home Phone: ( ) May we leave a message? ___Yes ___No

Cell/Other Phone: ( ) May we leave a message? ___Yes ___No

Cell/Other Phone: ( ) May we leave a message? ___Yes ___No

E-mail: _____ May we email you? ___Yes ___No

Alt. E-mail: _____ May we email you? ___Yes ___No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Insurance company: _____

Group# _____ ID#_____

Name of Policy Holder: _____

Policy Holder's Date of Birth:_____

Referred by (if any): _____

You have contacted this therapist for services regarding your family. In order to obtain a more comprehensive understanding of your family, please complete this form.

Feel free to leave any question blank, but also consider that more information may allow me the opportunity to tailor the treatment plan to effectively meet your needs.

What prompted you to seek services?

_____

How long has this been a problem? _____

Do other family members view themselves as having a problem?_____

If so, how would they describe the problem?_____

What specific symptoms/problems do you think are relevant? Please check all that apply.

__ Communication problems
__ Conflicts over parenting styles
__ Grief or loss issues
__ Problems with extended family
__ Problems with alcohol/drugs
__ School stressors
__ Financial problems
__ Trust issues
__ Health issues
__ Conflicts over values
__ Mental Health issues
__ Work stressors

In the space below, please feel free to further explain any of the above items or list other issues that you believe to be problematic.

What profound losses has your family experienced in the past few years?

SIGNIFICANT RELATIONSHIPS/FAMILY INFORMATION

Tell me about the people in your family and others who may affect your family

Relationship (add children, siblings, close friends, etc.)	**Name**	**Age** (If deceased, when?)	**Living with? or frequency of contact?**

PARENTAL INFORMATION

_____ Parents married/partnered, how long? _____

_____ Parents separated, how long ago?_____

_____ Parents divorced, how long ago? _____

_____ Father remarried: Number of times _____

_____ Mother remarried: Number of times _____

Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.)

SOCIAL RELATIONSHIPS

What activities does your family enjoy together?

Does your family participate in a social circle? If so, whom?

Outside of the nuclear family, who is your family's strongest support?

CULTURAL / ETHNIC

To which cultural or ethnic group, if any, do you belong? _____

Cultural and Ethnic strengths:

Cultural and Ethnic stressors/problems:

SPIRITUAL / RELIGIOUS

How important to your family are spiritual matters? ____ Not ___ Little ___ Moderate __ Much

Are you affiliated with a spiritual or religious group? ____No _____Yes (describe)

_____

If you are affiliated with a spiritual or religious group, how frequently do you participate in this community?

MEDICAL / PHYSICAL HEALTH

_____ Active Medical Problems ____ Past Hospitalizations
_____ Major Medical Illness ____ Other Medical Problems (describe) _____

If any above items checked, please describe:

COUNSELING / PRIOR TREATMENT HISTORY

Has your family ever participated in any previous counseling/therapy services? _____ No _____ Yes (describe when/where)

_____

Is anyone in the family currently seeing a therapist? _____ No _____ Yes If so, who and who are they seeing?

_____

_____

Has any family member ever been hospitalized for substance abuse or psychiatric care?
_____ No _____ Yes (who/when/where/why?)

Is anyone in your family on psychotropic medication?
_____ No _____ Yes (who? what medication? for what diagnosis/symptoms?)

STRENGTHS AND NEEDS

What do you see as your family's strengths?

Is there any other information about you that you think is relevant for your family's treatment planning?

Please list at least one goal you would like to reach during the course of your family's treatment.

_____ _____
NAME

_____
RELATIONSHIP TO THE FAMILY