INTAKE FOR FAMILY THERAPY

Client Name _____(person to initiate therapy)

Mother's Name: _____Age:_____Occupation:_____

Father's Name: _____Age:_____Occupation:_____

CHILDREN (list oldest to youngest)

Name:_____Age:_____Birthdate:_____

Name:_____Age:_____Birthdate:_____

Name:_____Age:_____Birthdate:_____

Name:_____Age:_____Birthdate:_____

List additional children on the back

Parents: ◯ Married ◯ Live Together; ◯ are Divorced ◯ are Separated

◯ Remarried ◯ Deceased ◯ Other: _____

Children live with:

◯ Both Parents; ◯ Father; ◯ Mother; ◯ Other:_____

Primary Address:_____

PLEASE LIST ANY ADDITIONAL PERSONS LIVING IN HOME (RE: Grandparents, cousins, friends, step-kids etc.)

HOUSEHOLD MEMBERS	**RELATIONSHIP**	**Birthdate/Age**

PLEASE LIST ANY ADDITIONAL PERSONS LIVING IN HOME (RE: Grandparents, cousins, step-kids, friends, etc.)

Secondary Address:_____

HOUSEHOLD MEMBERS	**RELATIONSHIP**	**BIRTHDATE/AGE**

CONTACT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please fill out if the billing address is different

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number (Please indicate the best one to call)

PRIMARIAY CONTACT

NAME: _____

Best time(s) to call: _____ Okay to leave a limited message?

◯ Home: _____ ◯ Yes ◯ No

◯ Work: _____ ◯ Yes ◯ No

◯ Cell/other: _____ ◯ Yes ◯ No

SECONDARY CONTACT

NAME: _____ RELATIONSHIP _____

Best time(s) to call: _____ Okay to leave a limited message?

◯ Home: _____ ◯ Yes ◯ No

◯ Work: _____ ◯ Yes ◯ No

◯ Cell/other: _____ ◯ Yes ◯ No

ADDITIONAL CONTACT

NAME: _____ RELATIONSHIP _____

Best time(s) to call: _____ Okay to leave a limited message?

◯ Home: _____ ◯ Yes ◯ No

◯ Work: _____ ◯ Yes ◯ No

◯ Cell/other: _____ ◯ Yes ◯ No

Best Available times for Appointments (Please check all available days)

◯ Monday Times: _____

◯ Tuesday Times: _____

◯ Wednesday Times: _____

◯ Thursday Times: _____

◯ Friday Times: _____

◯ Saturday Times: _____

BACKGROUND HISTORY

DESCRIPTION OF PROBLEM (what, who is involved, when did or does it occur, how often does it occur, etc.)

WHY HAVE YOU CHOSEN TO SEEK COUNSELING AT THIS TIME?

HOW HAVE YOU TRIED TO SOLVE THE PROBLEM?

WHAT HAS BEEN SUCCESSFUL/UNSECCCESSFUL?

FAMILY HISTORY OF MENTAL ILLNESS

PREVIOUSE COUNSELING EXPERIENCE (with whom, reactions, outcome):

PLEASE DESCRIBE ANY SIGNIFICANT TRAUMAS, LOSSES, OR SEPARATIONS YOUR FAMILY HAS EXPERIENCED:

PLEASE CHARACTERIZE THE NATURE OF RELATIONSHIPS BETWEEN FAMILY MEMBERS

ARE THERE ISSUES IMPACTING OTHER FAMILY MEMBERS OR THE FAMILY AS A WHOLE? DESCRIBE

ADDITIONAL INFORMATION

1. IS THIS COUNSELING COURT ORDERED? ◯ YES ◯ NO
2. IS SOCIAL SERVICES INVLOVES? ◯ YES ◯ NO
3. IS THE SITUATION URGENT? ◯ YES ◯ NO
4. IS THE CLIENT OR ANYONE IN THE FAMILY CONSIDERING /THREATENING SUICIDE? ◯ YES ◯ NO
5. IS THERE A HISTORY OF SUICIDE ATTEMTPS? ◯ YES ◯ NO
6. IS THERE PHYSICAL CONFLICT PRESENT, SUCH AS HITTING, PUSHING,SLAPPING, BLOCKING EXITS PHYSSICAL TRHEATS, OR ANY FEAR OF THESE? ◯ YES ◯ NO
7. IS THERE OTHER LEGAL INVOLVEMENT? ◯ YES ◯ NO
8. IS THERE A HISTORY OF PSYCHIATRIC HOSPITALIZATION? ◯ YES ◯ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE PLEASE EXPLAIN:

OTHER PRESENTING INFORMATIOJN:

NAME OF PERSON FILLING OUT FORM _____

INTAKE COMPLETED BY: _____DATE:_____