Family Intake Form

Family Last name: _____. Date today: _____--

Please list those who will be present for counseling

Father's Name:_____ Phone:_____

Address:_____

City: _____ State: _____ Zip: _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender:_____ DOB: _____ Religious Affiliation: _____

Employer:_____ Occupation:_____

Marital Status: (circle one) Single Engaged Married (years married) Separated Divorced

Mother's Name:_____ Phone:_____

Address: ☐ Same as above or if separate:

City: _____ State: _____ Zip:_____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender:_____ DOB: _____ Religious Affiliation:

Employer:_____ Occupation:

Marital Status (circle one): Single Engaged Married (years married). Separate Divorced

**If children are stepsiblings or partial siblings please indicate next to their name*

Children: Name Age

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Mental Health:

Has anyone in the immediate family currently or historically been suicidal? ☐ Yes ☐ No

If yes, who and when? _____

Has anyone in the immediate family been hospitalized for mental health related issues? ☐ Yes ☐ No

If yes, who and when? _____

Is anyone in the immediate family currently receiving counseling services with another professional? ☐ Yes ☐ No

If yes, who and for how long? _____

Reasons for Seeking Family Counseling:

_____

_____

_____

How would you know that your time in therapy has been successful? What would look different in your family? _____

_____

List some strengths in your family: _____

_____

List some weaknesses in your family: _____

_____

How does your family deal with conflict? _____

_____

How does your family celebrate/play together? _____

_____

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What are things that your family does together on a regular (weekly) basis_____

_____

How does your family deal with major life events (i.e. weddings, deaths, life threatening illnesses, job loss)?_____

_____

_____

__

Has anyone in the family ever struck, physically restrained, used violence against, or injured any person within the family? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Referred by:

☐ Therapist ☐ Church ☐ Physician ☐ Agency ☐ Friend ☐ Internet

Emergency Contact Name:

Relationship:_____ Phone Number:

Client Signature:_____Date:_____

Client Signature:_____Date:_____