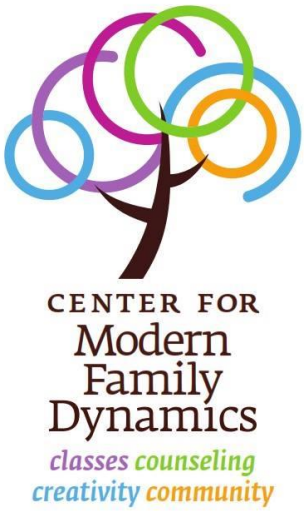

Family Intake and Demographics

Name:_____ Date: _____

Address: _____ City:_____State:_____Zip:_____

County:_____ Phone: (H) _____ (C) _____ (W) _____

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

It is customary practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address here:

_____

Family Information: *Please list those who will be present for counseling*

Mothers Name: _____ Age: _____ DOB: _____

Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (how long ___) **Divorced** (how long ___) **Widowed**

Father's Name: _____ Age: _____ DOB: _____

Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (how long ___) **Divorced** (how long ___) **Widowed**

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

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Mental Health:

- Is anyone in the immediate family currently or historically been suicidal? (if so who and when?)

  _____
- Is anyone in the immediate family ever been hospitalized for mental health related issues?

  _____
- Is anyone in the immediate family currently receiving counseling services with another professional? If so who and for how long?

  _____

1) What are the primary issues of concern within your family that has led you to seek family counseling services?

_____
_____
_____

2) On a scale of 1 to 10 where 1 is not at all helpful and 10 is Extremely helpful, how helpful do you think therapy will be in helping your family with what they came in for today. _____

3) List some strengths in your family:

_____

4) List some weaknesses in your family:

_____

5) How does your family deal with conflict?

_____

6) How does your family celebrate/play together?

_____

7) What are things that your family does together on a regular (weekly) basis?

_____

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

_____

9) Has anyone in the family ever struck, physically restrained, used violence against or injured any other person within the family? (If yes, please explain) _____

_____

10) How would you know that your time in therapy has been successful? What looks different in your Family?

_____

_____

_____

Referred by: _____

Emergency contact information:

Name _____

Relationship: _____ **Phone:** _____

Client Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____