Name of primary contact for family:

Phone Number: Is it ok to leave voicemail? Is it ok to send text message appointment reminders?

Email address:

Secondary contact for family:

Phone Number: Is it ok to leave voicemail? Is it ok to send text message appointment reminders?

Email address:

Address :

Please list any medications for mental health anyone in the family is currently taking:

Who is your current prescriber for mental health medications?

**Religious Affiliation:**

Father’s Religious upbringing:

Present Affiliation:

Is this an important part of your life?

Why/why not?

Mother’s Religious upbringing:

Present Affiliation

Is this an important part of your life?

Why/why not?

Family unit’s religious affiliation:

Is religious differences a source of tension for your family? Yes No

**Ethnicity:** Asian/Pacific Islander American Indian Hispanic African American Caucasian Other**):**

**Family Composition:**

Parents relationship status:

\_\_\_\_Single \_\_\_\_Partnered \_\_\_\_Married \_\_\_\_Separated \_\_\_\_Divorced \_\_\_\_Widowed

If married/partnered, how long together?

Children and ages:

Do all children live with you? Please explain living situation of all children:

CHILD 1

Name: DOB:

School: Grade:

How does your child do in school academically?

How does your child do in school behaviorally?

Does your child have a learning or physical disability? Yes No Specify:

Does your child have a mental health diagnosis? Yes No

Specify:

Biological Mom: DOB:

Married\_\_/\_\_/\_\_ Separated \_\_/\_\_/\_\_ Divorced\_\_/\_\_/\_\_

**Family History/Development:**

List any pertinent family history of medical, mental health, or substance abuse problems:

Please briefly identify main reasons for seeking therapy:

Please list the goals you wish to achieve in counseling. Consider the way you would like to feel, problems you wish to solve, and coping skills you would like to learn:

Has any family member(s) been a victim of sexual, physical, emotional, or verbal abuse? Yes No. If yes, please explain

Are there other unusual/traumatic circumstances that affected your family’s development? Yes No

If Yes, please describe:

Are there any open CPS cases involving members of the family? Yes No

Are there any legal cases/issues your family is facing? Yes No

I understand that Ms. Kleinhans believes it is in the best interest of the families/ individuals she helps to not get involved in custody disputes and court proceedings. The services she provides are focused on family members’ relational and emotional well-being. Legal advice is beyond her scope of practice and she will not testify or be a witness in legal proceedings.

\_\_\_\_\_\_\_ (Father’s Initials) \_\_\_\_\_\_\_ (Mother’s Initials)

How does child 1 handle anger?

Has child 1 experienced any significant loss? Yes No

If yes, explain:

What do you view as your child/teen’s major strengths and positive traits?

What are your child/teen’s hobbies?

Where do you believe your child/teen is spiritually?

Briefly describe your goals for child 1’s therapy:

Please list any information you deem to be important for the therapist to know about Child 1:

Tell anything else in the space below that you think would be helpful for me, as your Family Therapist, to know:

Please state what kind of family goals you would like to work on in therapy:

**Additional Children:**

CHILD 2

Name: DOB:

School: Grade:

 How does your child do in school academically?

How does your child do in school behaviorally?

Does your child have a learning or physical disability? Yes No Specify:

Does your child have a mental health diagnosis? Yes No

Specify:

Biological Mom: DOB:

Married\_\_/\_\_/\_\_ Separated \_\_/\_\_/\_\_ Divorced\_\_/\_\_/\_\_

How does child 2 handle anger?

Has child 2 experienced any significant loss? Yes No

If yes, explain:

What do you view as your child/teen’s major strengths and positive traits?

What are your child/teen’s hobbies?

Where do you believe your child/teen is spiritually?

Briefly describe your goals for child 2’s therapy:

Please list any information you deem to be important for the therapist to know about Child 2:

CHILD 3

Name: DOB:

School: Grade:

How does your child do in school academically?

How does your child do in school behaviorally?

Does your child have a learning or physical disability? Yes No Specify:

Does your child have a mental health diagnosis? Yes No

Specify:

Biological Mom: DOB:

Married\_\_/\_\_/\_\_ Separated \_\_/\_\_/\_\_ Divorced\_\_/\_\_/\_\_

How does child 3 handle anger?

Has child 3 experienced any significant loss? Yes No

If yes, explain:

What do you view as your child/teen’s major strengths and positive traits?

What are your child/teen’s hobbies?

Where do you believe your child/teen is spiritually?

Briefly describe your goals for child 3’s therapy:

Please list any information you deem to be important for the therapist to know about Child 3:

(Please list additional children on the back)