FAMILY THERAPY INTAKE FORM

*Fill out Individually (for each client over 13)

First name: _____ Last name: _____

Age: _____ Date of Birth: _____ Ethnicity: _____

Religion: _____ Marital Status: _____ Sex/gender: _____

Number of children: _____ Ages of children: _____

Home address: _____

Who do you live with? _____

Cell #: _____ Home #: _____

Work #: _____ Email: _____

Name of emergency contact: _____ Phone: _____

EMPLOYMENT INFORMATION:

☐ On sick leave, as of this date: _____ Return to work date: _____

I was: ☐ Full-time or ☐ Part-time at: _____ Position: _____

☐ Full-time at: _____ Position: _____

☐ Part-time at: _____ Position: _____

☐ Not working because: _____

PSYCHIATRIC AND MEDICAL HISTORY:

Please list any psychiatric or "mental" problems you have been diagnosed with:

_____

_____

_____

Please list any medical or "physical" problems that you have been diagnosed with:

_____

_____

_____

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Please list any medications you currently take, and what you take them for:

_____

_____

_____

_____

Name of Family doctor: _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

Results: _____

_____

Name of Psychiatrist: _____ Phone: _____

Last visit was during the month of: _____ Year: _____

Results: _____

MENTAL HEALTH TREATMENT HISTORY

Have you ever been hospitalized for psychological or psychiatric reasons? ☐ No ☐ Yes

If yes, please describe when and where you were hospitalized, and for which reasons.

_____

_____

_____

Have you received prior family counselling? And, if yes, for what problems? ☐ No ☐ Yes

If yes, when: _____ Where: _____

By whom:_____ Length of treatment:_____

Problems treated:_____

_____

Was the outcome successful? ☐ Very ☐ Somewhat ☐ No change ☐ Got worse

Have you ever been in individual counselling before? ☐ No ☐ Yes

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If yes, give a brief summary of concerns you addressed

_____

_____

CURRENT HABITS

Please describe your current habits in each of the following areas:

Smoking: _____

Gambling: _____

Drinking: _____

Drug use: _____

Caffeine intake: _____

Exercise: _____

Eating: _____

Sleeping: _____

Fun and relaxation: _____

STRESSFUL LIFE EVENTS

Please describe any current significant or stressful life events that you have been experiencing:

Economic problems? _____

Difficulty accessing health care? _____

Legal issues or crime? _____

Cultural issues? _____

Family conflict or lack of support? _____

Social problems? _____

Educational or occupational difficulties? _____

Housing problems? _____

Grief or bereavement? _____

Other? _____

FAMILY THERAPY INTAKE FORM

QUESTIONS ABOUT YOUR FAMILY

How close you feel to your family members: (distant) 1 2 3 4 5 (close)

How well you get along with your family members: (poorly) 1 2 3 4 5 (great)

What are the family and/or household rules/expectations? _____

_____

_____

What are your expectations for counselling: _____

_____

_____

What are your treatment objectives (please check all that apply):

☐ Improve communication ☐ Conflict resolution ☐ Parenting skills ☐ Problem solving

☐ More emotional safety ☐ More physical safety ☐ More quality time together

☐ Resolve individual issues ☐ More autonomy ☐ More respect/understanding

☐ Power and control issues ☐ More hobbies ☐ Less harsh discipline

☐ More sharing of the chores ☐ Help for children's behavior

☐ Other (specify): _____

What have you already tried to address these difficulties?_____

_____

_____

Whose idea was it to come to therapy? _____

Was there a prompting event that led someone to make this call? (Why seek help now?) _____

_____

_____

_____

What are your biggest strengths as a family? _____

_____

FAMILY THERAPY INTAKE FORM

_____

_____

Please make at least three suggestions as to something you could personally do to improve the relationship regardless of what your family members do: _____

_____

Does anyone in your family drink alcohol or take drugs to intoxication? ☐ Yes ☐ No

If yes, who, how often and what drug/alcohol? _____

_____

_____

Has anyone in your family physically restrained, harmed, or injured the other person? E.g., pushed, shoved, grabbed, or slapped, etc. ☐ Yes ☐ No

If yes, who, how often and what happened? _____

_____

_____

Is your family at risk for splitting up? ☐ Yes ☐ No ☐ Unsure

If yes or unsure, please describe _____

_____

_____

Do you perceive that anyone in your family has withdrawn or given up trying to work things out? □ Yes □ No

If yes, who? _____

Circle your current level of stress overall? (No stress) 1 2 3 4 5 (extremely stressed)

Circle your current level of stress in the family? (No stress) 1 2 3 4 5 (extremely stressed)

Name the top three concerns that you have in your family ("1" being the most problematic):

1. _____

2. _____

3. _____

Full of Heart

FAMILY THERAPY INTAKE FORM

How important is it to you to improve the quality of your family relationships?

(not important) 1 2 3 4 5 6 7 8 9 10 (extremely important)

How willing are you to make “working on these relationships” a priority in your life?

(not willing) 1 2 3 4 5 6 7 8 9 10 (extremely willing)

Is there anything else that you would like to mention? _____

_____

_____

_____ _____

Signature Date