

INTAKE FORM for FAMILY COUNSELLING

PARTICIPANTS IN FAMILY SESSIONS

Names and ages of responsible adults (parents/guardians). Please indicate relationship to children (mother, father, stepfather/mother, legal male/female guardian, grandmother/father, etc.).

| Name | Relationship | Age |
|----------|--------------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |

Names and ages of children

| Name | Age | Name | Age |
|----------|-------|----------|-------|
| 1. _____ | _____ | 5. _____ | _____ |
| 2. _____ | _____ | 6. _____ | _____ |
| 3. _____ | _____ | 7. _____ | _____ |
| 4. _____ | _____ | 8. _____ | _____ |

PRINCIPLE FAMILY MEMBERS *NOT* ATTENDING SESSIONS

(eg. biological or step parents, siblings, or others who may live elsewhere, etc. yet play a significant role in family dynamics)

| Name | Relationship | Age |
|----------|--------------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

CONTACT INFORMATION

Name of primary contact person _____

Address _____

Phone Number _____ Is it okay to leave messages?
(best number to reach you at) Yes No

Email address _____
(if you are comfortable with this form of contact)

Emergency Contact _____
(someone *NOT* attending sessions) Name _____ Phone Number _____

HEALTH CONCERNS IN THE FAMILY

Please indicate the health concerns in your family.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Pain or Fatigue | <input type="checkbox"/> Hyper/Hypo Glycemia | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> AD/HD | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyper/Hypo Thyroid | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach or Digestive Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Debilitating Injury | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis | Other: _____ |
| <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Panic Attacks | |
| <input type="checkbox"/> Borderline Disorder | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Schizophrenia | |

HEALTH CONCERNS CONT...

Please indicate if any family members have concerns with any of the following:

| | Name | | Name |
|---|-------|---|-------|
| Feelings of sadness, crying, being down | _____ | Concerns about sexuality | _____ |
| Racing thoughts | _____ | Use of alcohol or drugs | _____ |
| Unwanted or intrusive thoughts | _____ | Doing things over and over | _____ |
| Times when I can't control what I do | _____ | Seeing or hearing things that other's don't | _____ |
| Sleep problems | _____ | Feeling anxious or nervous | _____ |
| Feeling worthless | _____ | Special needs | _____ |
| Difficulty controlling my temper | _____ | Spiritual concerns | _____ |
| Eating problems | _____ | Some things are too painful to talk about | _____ |

Have you been in counselling before? Yes No If so, when _____

Briefly describe the reason for seeking counselling at that time.

OVERALL FAMILY HEALTH OR CONNECTEDNESS

In general, family dynamics are 1 2 3 4 5 6 7 8 9 10
poor excellent

Please check if the family is dealing with Abuse Addiction(s) Affair(s) Incest Financial strain

Comments:

Please check which statement best applies to your family situation:

- We are a well-adjusted/well-connected family. We do alright but have some areas of concern.
 We're functioning but just barely. We're a complete mess.

Principle concern/reason for seeking family counselling at this time:

Thank you for taking the time to complete this form.
Feel free to call me with any questions or concerns, or mention them when we meet.