FAMILY THERAPY INTAKE FORM
Fill out Individually
(for clients ages 14+)

First name: ____________________ Last name: ______________________________________
Age: ________ Birth day: ______ Month: _______________ Year:_____________________
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: _________________________

CHILDREN:

Name/Age:____________________________________

Name/Age:_____________________________________

Name/Age:_____________________________________

Name/Age:_____________________________________

SIGNIFICANT KIN/FAMILY who do not live with you:

_______________________________________________

_______________________________________________

_______________________________________________

EMPLOYMENT INFORMAITON:
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:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Name of Family doctor: ________________________Phone: ____________________________

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? □Yes □ No 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? □ Yes □ No 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:
Meditation:
Eating:
Sleeping:
Time in Nature:
Fun and relaxation:
Artistic expression:

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

| | No | Yes | If yes, please describe |
|---|---|---|---|
| Economic problems? | | | |
| Difficulty accessing health care? | | | |
| Legal issues or crime? | | | |
| Cultural issues? | | | |
| Systemic/Institutional issues | | | |
| Family conflict or lack of support? | | | |
| Social problems? | | | |
| Educational challenges? | | | |
| Occupational difficulties? | | | |
| Housing problems? | | | |
| Grief or bereavement? | | | |
| Other? | | | |

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?

___

___

___

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?

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?

How does your family typically resolve conflict?

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. ______________________________________________________

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)

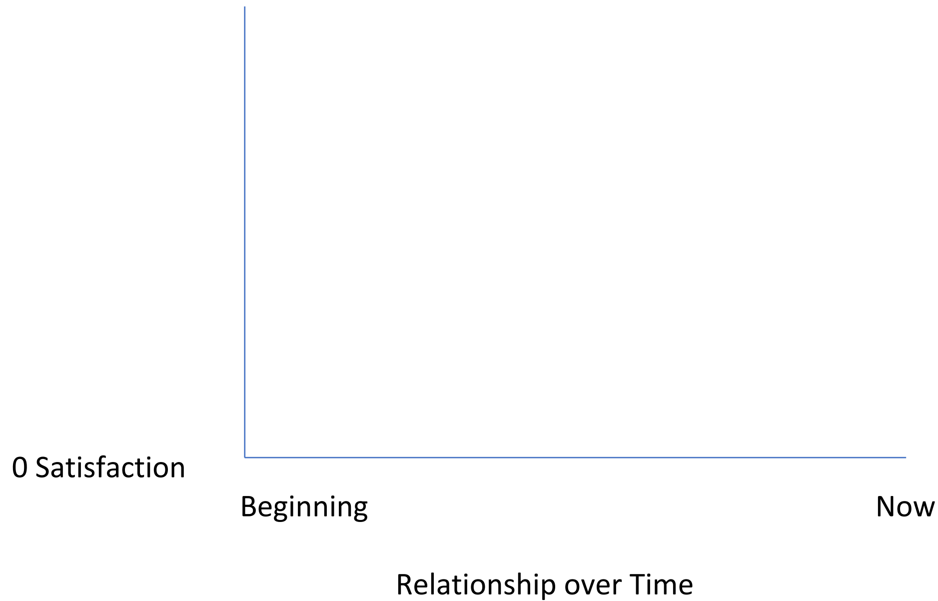
How willing are you to make "working on these relationships" a priority in your life?
(not willing) 1 2 3 4 5 6 7 8 9 10 (extremely willing)

Do you have and/or practice a spiritual faith:
Yes No

If yes, please describe:
____________________________________________________________
____________________________________________________________
____________________________________________________________

Lastly, please draw a graph indicating your level of family satisfaction from the start until now. Mark significant events in your life (e.g., birth of a child, puberty, remarriage, etc.).

100 Complete Satisfaction




How would you know that your time in therapy has been successful? How would your family look different if you woke up one day and your problems solved?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Is there anything else you'd like me to know?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________