Family Therapy Intake Paperwork

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Today's Date: (mm/dd/yyyy) _____ Form filled out by:_____

Please fill out lines for all of those involved in Family Therapy. Put an asterisk next to each individual involved in therapy. Please include other family members where applicable. If you are in a blended family, please include information for ex-partners and step-children as well.

Name	Age	Date of Birth	Gender	Family Role	Job

Residential Street Address: _____
Primary Phone #: _____ May I leave a message for you at this number?_____
Email address: _____ Is it okay to use email to contact you?_____
Preferred method of contact: _____ Preferred times to contact you if by phone: _____
Legal Guardian(s) (if applicable): _____
Referral Source:_____

Emergency Contact Information

Emergency Contact Person(s): _____ Phone #: _____
Emergency Contact Person(s) Relationship to Client: _____

Payment Information

Who will be responsible for your bill?_____Will you be paying by cash, check, or Venmo? _____
Do you have out of network insurance benefits that might apply? Yes☐ No☐ Unsure☐

Medical Information

Are there any medical issues I should be aware of for any family members?_____
_____

Please list any prescription medications currently being taken by family members (and by whom):_____
_____
_____
Please list any over the counter medications, vitamins, or herbal supplements presently taken and by whom:
_____
_____

Mental Health Information

Have you ever been in counseling/therapy before as a family or individually (please signify who)? _____

When? _____ If yes, did you find it helpful or effective (and what about it)?_____

Are any of you currently receiving mental health services? If yes, please list name of practitioner and type of services you are receiving: _____

Have any of you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed? _____

Briefly describe why you are coming in for counseling and the goals you hope to achieve in therapy:

Family History

Family History of (mark with an 'x' all that apply; if it applies to someone in the family, write first initial):

	Mother	Father	Siblings	Grandparents	Aunt/Uncle
Alcohol Substance Abuse:					
History of Completed Suicide					
History of Mental Illness:					
Depression					
Schizophrenia					
Bipolar Disorder					
Alzheimer's					
Anxiety					
Attention Deficit/Hyperactivity					
Learning Disorders					
School Behavior Problems					
Incarceration					
Other					
Comments:					

Leisure

What do you like to do together as a family?_____

What community involvement(s) do you currently have? (ie groups, clubs, activities):_____

Financial Assistance *(mark with an 'x' those that apply):*

__ Food Stamps/EBT __ TANF __ SSI __ SSDI __ SSA (retirement) __ Other Retirement Income

__ Medicaid __ Medicare __ General Assistance

Thank you for filling out this information. It will greatly assist us in our work together. Please have each participating family member fill out the Signature Page document.