

**Family Form**  
**(to be completed by client)**

Date \_\_\_\_\_

Name: \_\_\_\_\_

Spouse/Partner: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Referred by: \_\_\_\_\_ Address: \_\_\_\_\_

ADULT #1: Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Business: \_\_\_\_\_

Work Address: \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

ADULT #2: Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Business: \_\_\_\_\_

Work Address: \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Check your current living situation.

- Married     Divorced     Separated     Single     Engaged  
 Remarried     Significant Other     Widowed     Cohabiting

For how long have you been married, divorced, etc.? \_\_\_\_\_

Have either you or your spouse/partner been married before? \_\_\_\_\_

How long were each of you married to ex-spouse? \_\_\_\_\_

Children/Siblings (include biological, adopted, foster, step, etc.):

<u>Name:</u>	<u>Sex:</u>	<u>Age:</u>	<u>Type (child or sibling and bio, step, etc.):</u>	<u>Living with you?</u>
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there any other person in your household?  Yes  No

If yes, please give their names and their relationship to your family.

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ADULT #1:

Are your parents living? Mother:  Yes  No Father:  Yes  No

If yes, please give their names, address(es), and telephone number(s).

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ADULT #2:

Are your parents living? Mother:  Yes  No Father:  Yes  No

If yes please give their names, address(es), and telephone number(s).

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### PREVIOUS COUNSELING HISTORY

ADULT #1: From: \_\_\_\_\_ To: \_\_\_\_\_ With Whom? \_\_\_\_\_

For What? \_\_\_\_\_

ADULT #2: From: \_\_\_\_\_ To: \_\_\_\_\_ With Whom? \_\_\_\_\_

For What? \_\_\_\_\_

### BASIC HEALTH

ADULT #1:  Good  Fair  Poor When was your last physical exam? \_\_\_\_\_

Who is your Physician? \_\_\_\_\_

Are you taking any prescription medication at this time?  Yes  No

If yes, What? \_\_\_\_\_

Are you taking any over the counter medications, herbs, supplements, etc.?  Yes  No

If yes, what? \_\_\_\_\_

Are you taking any medications for allergies?  Yes  No

If yes, what? \_\_\_\_\_

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of?  Yes  No

If yes, what? \_\_\_\_\_

Have you ever been hospitalized?  Yes  No If so, for what? \_\_\_\_\_

ADULT #2:  Good  Fair  Poor When was your last physical exam? \_\_\_\_\_

Who is your Physician? \_\_\_\_\_

Are you taking any prescription medication at this time?  Yes  No

If yes, What? \_\_\_\_\_

Are you taking any over the counter medications, herbs, supplements, etc.?  Yes  No

If yes, what? \_\_\_\_\_

Are you taking any medications for allergies?  Yes  No

If yes, what? \_\_\_\_\_

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of?  Yes  No

If yes, what \_\_\_\_\_

Have you ever been hospitalized?  Yes  No If so, for what? \_\_\_\_\_

CHILDREN: Do any of your children have any physical, emotional, or mental condition now or in the past that I need to be aware of?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REASON(S) FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to see happen as a result of counseling?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The thing which concerns me the most right now is?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IT IS CUSTOMARY TO PAY YOUR THERAPIST AFTER EACH SESSION.

\* A Counseling Session is normally \_\_\_\_ minutes.

POLICY

A ~~72~~<sup>48</sup>-HOUR CANCELLATION NOTICE IS APPRECIATED; OTHERWISE USUAL FEE WILL BE CHARGED.

I understand that suicidal threats, homicidal threats or child abuse by an adult to a child will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

Signatures \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_