



Family Intake Form

Family Information

Please list those who will be present for counseling

Father's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Email: _____ Method of contact: (*circle one*) Phone or Email

Age: _____ Gender: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (*circle one*) ☐ Single ☐ Engaged ☐ Married (____ years married) ☐ Separated ☐ Divorced

Mother's Name: _____ Phone: _____

Address: ☐ Same as above _____

City: _____ State: _____ Zip: _____ County: _____

Email: _____ Method of contact: Phone or Email (*circle one*)

Age: _____ Gender: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (*circle one*) ☐ Single ☐ Engaged ☐ Married (____ years married) ☐ Separated ☐ Divorced

Children: Name Age

_____	_____
_____	_____
_____	_____
_____	_____

*If children are stepsiblings or partial siblings please indicate next to their name

Mental Health

Has anyone in the immediate family currently or historically been suicidal? ☐ Yes ☐ No

If yes, who and when? _____

Has anyone in the immediate family been hospitalized for mental health related issues? ☐ Yes ☐ No

If yes, who and when? _____

Is anyone in the immediate family currently receiving counseling services with another professional?

☐ Yes ☐ No If yes, who and for how long? _____



Reasons for Seeking Family Counseling:

How would you know that your time in therapy has been successful? What would look different in your family? _____

List some strengths in your family: _____

List some weaknesses in your family: _____

How does your family deal with conflict? _____

How does your family celebrate/play together? _____

What are things that your family does together on a regular (weekly) basis? _____

How does your family deal with major life events (i.e. weddings, deaths, life threatening illnesses, job loss)? _____

Has anyone in the family ever struck, physically restrained, used violence against, or injured any person within the family? ☐ Yes ☐ No If yes, please explain: _____

Referred by: _____

☐ Therapist ☐ Church ☐ Physician ☐ Agency ☐ Friend ☐ Internet

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____