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 ☐ Cohabitating

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

Have either you o r your spouse/partner been married before? _____

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

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

Name:	Sex:	Age:	Type (child or sibling and bio, step, etc.):	Living with you?
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No

Is there any other person in your household? ☐ Yes ☐ No

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

_____

_____

ADULT #1:

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

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

_____

_____

ADULT #2:

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

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

_____

_____

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 50 minutes.