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Family Intake Form
The rules and limits of confidentiality apply to the information included in this form

Adult's Name: ______________________	Adult's Name: ______________________
Social Security #: ______________	Social Security #: ______________
Date of Birth ____________	Date of Birth ____________
Age __________	Age __________
Phone Numbers: May I contact you at the following:	Phone Numbers: May I contact you at the following:
Home ( ) yes/no	Home ( ) yes/no
Cell ( ) yes/no	Cell ( ) yes/no
Work ( ) yes/no	Work ( ) yes/no
Email: ____________________yes/no	Email: ____________________yes/no
Employer/School ________________	Employer/School ________________
Occupation: ____________________	Occupation ____________________
How long on present job? ____________	How long on present job? ____________
Last school grade completed____________	Last school grade completed: ____________
Primary Care Physician ______________	Primary Care Physician ______________
Phone # ______________________	Phone # ______________________
Emergency Contact ________________	Emergency Contact ________________
Phone # ______________________	Phone # ______________________

Marital Status: ____

Living with spouse/partner? ________________ Number of years together ______________

Names of children (please include dates of birth and names of parents):

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Address ____

____

Insurance Information
Health Plan/Insurance ______________________________ Policy # __________________
Phone # ___________________

Subscriber Name ______________________________ Subscriber SS #_____________
Mental Health Insurance (if different than above): ____

Major reasons for seeking help at this time: ____

____

____

____

How long have you had these problems or symptoms?: ______________________________________

____

How often do they occur? ____

____

What have you tried already? ____

____

Past or current psychiatric treatment: (who treated, type; provided by; year; helpful?)

____

____

____

Please describe any significant incidents, traumas, developmental concerns, learning issues that would be helpful for me to know about anyone in the family : ___________________________________

____

____

____

Does anyone in the family have any serious or chronic medical conditions or past surgeries? Please explain:

Has anyone in the family had any serious medical accidents or injuries, head injury or seizure history? Yes / No

If yes, please explain: ______

Does anyone in the family take any medications? Yes / No
If yes, please list: ______

Does anyone in the family use alcohol? Yes / No

How much per day/week ______
Age when started drinking? ______
Last drink taken (time and amount): ______

Does anyone in the family use drugs? Yes / No
What kind(s): ______
Amount/frequency: ______
Age started using: ______
Last use (time and amount): ______

Does anyone in the family feel a member has a problem with:
Alcohol: Yes / No
Drugs: Yes / No
If so, explain: ______

Previous treatment programs (dates, locations, if possible): ______

Has family member's drinking/drug use caused problems in the family or with relationships? ______

Has family member's drinking/drug use caused job problems? ______

Is it difficult for family member to stop or control the amount used? Yes / No

Have you or a family member ever been arrested for a D.U.I (driving under the influence) or other drug related offense(s)? Yes / No

Does anyone in the family use tobacco products? Yes / No
Who: ____
Amount/frequency: ____
Age when use started: ________________________ When did use stop? ____________________

How many cups of caffeinated beverages are consumed per day (coffee, tea, soda, energy drinks, etc):

____

Have any family members had any financial problems, legal difficulties/problems or previous incarceration? Yes / No
If yes, dates and details: ____

____

Have relatives/significant others had psychiatric symptoms or drug or alcohol problems?

____

____

Have any family members had problems with criminal offenses or been incarcerated? ________________

____

____

Others living in the home? (names, ages, relation)

____

____

____

Goals for Therapy: ____

____

____

Additional Information:

____