STICK & STONE COUNSELLING SERVICES

FAMILY INTAKE FORM

DATE: ______________________________

PRIMARY CONTACT:

LAST NAME: __________________________ FIRST NAME: ______________________________

HOME PHONE: ________________________ CELL PHONE: ______________________________

STREET ADDRESS: ____

CITY: ______________________________ PROVINCE: _____ POSTAL CODE: ____________

EMAIL: ____

D.O.B: _____________ AGE: ________ **M / F** RACE: ________________________

OCCUPATION: ____

LIST ALL FAMILY MEMBERS PARTICIPATING IN COUNSELLING, INCLUDING AGES AND RELATIONSHIPS:

NAME: ________________________ D.O.B: ________________ AGE: ________ **M / F**

RELATIONSHIP TO PRIMARY CONTACT: ____

NAME: ________________________ D.O.B: ________________ AGE: ________ **M / F**

RELATIONSHIP TO PRIMARY CONTACT: ____

NAME: ________________________ D.O.B: ________________ AGE: ________ **M / F**

RELATIONSHIP TO PRIMARY CONTACR: ____

NAME: ________________________ D.O.B: ________________ AGE: ________ **M / F**

RELATIONSHIP TO PRIMARY CONTACT: ____

NAME: ________________________ D.O.B: ________________ AGE: ________ **M / F**

RELATIONSHIP TO PRIMARY CONTACT: ____

NAME: ________________________ D.O.B: ________________ AGE: ________ **M / F**

RELATIONSHIP TO PRIMARY CONTACT: ____

CUSTODY ARRANGMENT (Please circle)

JOINT CUSTODY	SOLE CUSTODY	LEGAL GUARDIAN	LEGAL GUARDIAN(S)

IS THERE A COURT ORDER? **Y/N**

Are any of the following conditions a concern to at this time? (Please circle all that apply):

Improve Communication	Conflict Resolution	Parenting Skills	Problem Solving
More Emotional Safety	More Physical Safety	More Quality Time Together	Resolve Individual Issues
More Autonomy	More Respect/Understanding	Power And Control Issues	Mental Or Emotional Abuse
Less Harsh Discipline	More Sharing Of The Chores	Help With Children's Behaviour	Physical Abuse

Other (specify):

____

____

Briefly describe the main concerns or challenges that the family is currently facing: ____________________

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What specific goals or outcomes would you like to achieve through family therapy?

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Have any family members received counseling or therapy in the past? If yes, please provide details?

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Are there any significant medical or health-related issues within the family that the therapist should be aware of?

Are there any mental health disorders or diagnoses within the family that the therapist should be aware of?

Is anyone in the family on prescribed medications? If so, who and what are they taking?

FAITH: (Please circle)

ATHEIST AGNOSTIC CHRISTIAN JEWISH MUSLIM HINDU OTHER

Would you like faith incorporated into your treatment plan? **Y/N**

Thank you for taking the time to fill out this intake form. All information will be kept confidential.

If any questions or concerns arise, please feel free to discuss them with your counsellor.