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:

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

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

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.