Family Information Form

Your name: _____ Date_____

CHILDREN – Please list by age starting with the oldest DOB M F Age Grade School 1 / / 2 / / 3 / / 4 / /

1. _____ DOB _____ Age___ ☐M ☐F
2. _____ DOB_____ Age___ ☐M ☐F
3. _____ DOB_____ Age___ ☐M ☐F
4. _____ DOB_____ Age___ ☐M ☐F
5. _____ DOB_____ Age___ ☐M ☐F

Do both parents live together? ☐Yes ☐ No

If No, what's your visitation schedule? _____

Do you have joint custody? ☐Yes ☐ No

Have you notified your co-parent that you are bringing your child(ren) for services? ☐No ☐Yes

N/A; please explain_____

If you have joint legal custody, did your co-parent agree for your child(ren) to receive services?

☐No ☐Yes ☐N/A; please explain_____

Please note that I am **unable** to see kids who the other parent has declined consent for the kids to receive my services.

PLEASE FULLY COMPLETE FOR BOTH PARENTS/GUARDIANS

Name of Parent:_____ DOB_____

Home Address:_____

Phone:_____ ☐Cell ☐Work ☐Home Email:_____

Relationship History: Please check all that apply: ☐Married ☐Remarried ☐Divorced ☐Separated ☐Widowed

Name of Parent:_____ DOB_____

Home Address:_____

Phone:_____ ☐Cell ☐Work ☐Home Email:_____

Relationship History: Please check all that apply: ☐Married ☐Remarried ☐Divorced ☐Separated ☐Widowed

EMERGENCY CONTACT INFO

Name: _____

Relationship to client:_____

Phone: _____

HEALTH AND MEDICAL

Primary Care Physician:_____

Phone: _____

Psychiatrist: _____

Phone: _____

Please list any medical problems: _____

Any current medications: _____

Any use of controlled substances:_____

How did you hear about *Resilience Counseling, LLC*? _____

Counseling Information:

Briefly State the problem that has brought you/your family to counseling at this time.

Have you/your family ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ No ❑ Yes If yes, please describe:

Have you/your family ever taken medications for psychiatric or emotional problems?❑No ❑ Yes

If yes, please indicate:

Do any family members have a history of counseling or mental health diagnoses? ☐ No ☐ Yes

If Yes, please state:_____

Do your children have any developmental delays, special needs or learning disorders? ☐ No ☐ Yes

If Yes, please state:_____

Has there been any incidence of the following with you or members of your family?

Verbal Abuse: ☐ Past ☐ Present ☐ N/A Physical Abuse: ☐ Past ☐ Present ☐ N/A

Abuser: _____ Abused:_____ Abuser:_____ Abused:_____

Sexual Abuse: ☐ Past ☐ Present ☐ N/A Alcohol/Drug Abuse/Overdose: ☐ Past ☐ Present ☐ N/A

Abuser: _____ Abused: _____ Abuser:_____ Abused:_____

Suicide Attempts: ☐ Past ☐ Present ☐ N/A

Abuser: _____ Abused: _____

Are you currently or plan to be involved in any court proceedings? ☐ Yes ☐ No If Yes, Please describe:

Is there any additional information that you would like to disclose to me that you believe is applicable to your treatment here at Resilience Counseling, LLC? If so, please share:

Thank you!