LIFE SKILLS RESOURCE GROUP

Licensed Counselors, Life & Executive Coaching
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CONFIDENTIAL FAMILY INTAKE FORM

Parent's Name: _____ DOB: _____
Last First M

Address (City, State and Zip):_____

Marital Status: _____

Best Contact Number:_____ Email: _____

Step Parent(s)/Guardian(s): _____ DOB: _____
Last First M

Best Contact Number:_____Email: _____

Parent's Name: _____ DOB: _____
Last First M

Address (City, State and Zip):_____

Marital Status: _____

Best Contact Number:_____ Email: _____

Step Parent(s)/Guardian(s): _____ DOB: _____
Last First M

Best Contact Number:_____Email: _____

Child's Name:_____DOB: _____

Child's Name:_____DOB: _____

Child's Name:_____DOB: _____

Child's Name:_____DOB: _____

History of Problem:

1) Please describe what concerns you have regarding your family:_____

_____

_____

_____

1) How long has the problem existed: _____

_____

2) Have there been any significant stressors for the family in the last several years? (i.e. losses, births, deaths, moves, hospitalizations, financial problems, trauma, etc.):

_____

_____

_____

3) What attempts have been made to resolve the difficulties? _____

_____

4) Please indicate which family member, if any, are experiencing the following symptoms. Please indicate ***P for past*** and ***C for current***.

Symptom	Name(s)	Past or Current
Sadness or Depression		
Suicidal Thoughts/Talk		
Sleep Problems		
Changes in Appetite/ Weight Change		
Drug Use Alcohol Use Cigarette smoking		

Inability to Concentrate		
Obsessive Thoughts		
Tension, Worry/Anxiety		
Trouble with law		
Short attention span		
Compulsive Behaviors		
Withdrawn		
Acts of Violence		
Temper outbursts		
Stealing		
School performance		
Peer issues		
Defiant		

Phobias		
Sexual Abuse		
Sexually acting out		
Other		

Parent Information:

1) Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc)?

_____

_____

2) For Parents who are divorced, please state custody arrangements: _____

_____

3) Is ex-spouse (biological parent) aware that their child is coming to LSRG? Yes_____No _____

If not, please explain. _____

_____

4) Have any of your children been adopted? Yes_____No _____

Does your child know about the adoption? Yes_____No _____

What age was your child at the time of the adoption? _____

Mother's Name:_____Age:_____Occupation: _____

Significant medical problems: _____

_____

(Mother's information Continued)
Serious illnesses, accidents, or surgeries in the past: _____

_____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____History of arrest? _____

Primary Care Physician:_____Psychiatrist: _____

Step-parent/Guardian:_____Age:_____Occupation: _____

Significant medical problems: _____

_____

Serious illnesses, accidents, or surgeries in the past: _____

_____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____History of arrest? _____

Primary Care Physician:_____Psychiatrist: _____

Father's Name:_____Age:_____Occupation: _____

Significant medical problems: _____

_____

Serious illnesses, accidents, or surgeries in the past: _____

_____

(Father's information continued)
Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____History of arrest? _____

Primary Care Physician:_____Psychiatrist: _____

Step-parent/Guardian:_____Age:_____Occupation: _____

Significant medical problems: _____

_____

Serious illnesses, accidents, or surgeries in the past: _____

_____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____History of arrest? _____

Primary Care Physician:_____Psychiatrist: _____

Child Information:

1). **Name of Child**:_____ Age: _____

School:_____Grade:_____Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

(Child's information continued)
Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

_____

Pediatrician: _____ Psychiatrist: _____

2). **Name of Child**: _____ Age: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

_____

Pediatrician: _____ Psychiatrist: _____

3). **Name of Child**: _____ Age: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

_____

Pediatrician: _____ Psychiatrist: _____

4). **Name of Child**:_____ Age: _____

School:_____Grade:_____Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency): _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

_____

Pediatrician:_____ Psychiatrist: _____

Did someone refer you? Yes _____ No _____ Who? _____

1) Goals of counseling: (What would you like to see happen as a result of counseling?)

_____

_____

_____

2) Is there any other information that you believe would be helpful for the counselor to know?

_____

_____

_____

I understand that this information is being provided to my family's Counselor only. It is my responsibility to share relevant information with my child's Pediatrician/Primary Care Physician.

_____

Signature of the person completing this questionnaire Date Printed Name

_____

Signature of the person completing this questionnaire Date Printed Name