



FAMILY INTAKE FORM

PRIMARY CLIENT INFORMATION (child or adolescent receiving counseling)

Today's Date: _____

Full Name: _____

Birthdate: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____ Work: _____

Email: _____

May I leave a message for you at home? Yes___ No___ At work? Yes___ No___

If primary client is a child or adolescent, do they live with:
 Mother Father Both Other _____

PARENT (OR GUARDIAN) INFORMATION

Full Name: _____

Birthdate: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____ Work: _____

Email: _____

May I leave a message for you at home? Yes___ No___ At work? Yes___ No___

***** CONTINUE ON BACK OF FORM *****

SPOUSE / PARTNER (OR GUARDIAN) INFORMATION

Full Name: _____
Birthdate: _____ Age: _____ Gender: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: Home: _____ Cell: _____ Work: _____
Email: _____
May I leave a message for you at home? Yes ___ No ___ At work? Yes ___ No ___

ADDITIONAL FAMILY RELATIONS (list others who live with client)

Name: _____ Age: _____ Gender: _____ Relation to Client: _____
Name: _____ Age: _____ Gender: _____ Relation to Client: _____
Name: _____ Age: _____ Gender: _____ Relation to Client: _____
Name: _____ Age: _____ Gender: _____ Relation to Client: _____
Name: _____ Age: _____ Gender: _____ Relation to Client: _____
Name: _____ Age: _____ Gender: _____ Relation to Client: _____

EMERGENCY CONTACT

Name: _____ Relation to client: _____
Telephone: Home: _____ Cell: _____ Work: _____

Please describe briefly what changes you are hoping to make in coming to counseling now:
