Miki Johnston, MSW, LCSW
email@mikijohnstontherapy.com

Family Intake Form

Please fill out this form and bring it to your first session. Please note, the information provided here is protected as confidential information.

Mother's Name _____

Address _____ City, State Zip _____

Home Ph. _____ Cell Ph. _____ Work Ph. _____

E-mail _____ Occupation _____

Employer _____

Father's Name _____

Address _____ City, State Zip _____

Home Ph. _____ Cell Ph. _____ Work Ph._____

E-mail _____ Occupation _____

Employer _____

What is the best contact number for your family _____May I leave a message at this number?_____

How did you hear about my practice? _____

Parent's Marital Status: □ Married □ Never Married □ Separated □ Divorced □ Widowed

If applicable, Mother's number of previous marriages _____ Father's number of previous marriages _____

If applicable, Number of children from previous marriages _____

If divorced, please explain custody arrangement/details for client

_____

_____

_____

Will both parents be involved in the therapy □ No □ Yes

Party financially responsible for therapy _____

Children

Name	Age	Gender	School	Grade

Intake continued on next page…

Family Medical History:

Children's Primary Physician _____ Physician's phone number _____

List any current medications or supplements taken by family member (if any)?

Name of Family Member	Medication	Dosage	Date Started	Reason

List of Medical Conditions affecting any family members (if any)?

Name of Family Member	Condition	Date of Diagnosis	Details

Family Mental Health History:

If any family members have previously been or are currently being treated for mental health or substance abuse issues, please complete below:

Name of Family Member	Diagnosis	Date of Initial Diagnosis	Type of Treatment

Please provide information pertaining to each family member:

1. Name of Family Member: _____

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

Intake continued on next page…

(1st family member cont.)

Are you currently experiencing overwhelming sadness or depression?

□ No □ Yes If yes, for how long? _____

Rate the severity of the feeling on a scale of 1-5 (5 is most severe) _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes If yes, how long? _____

Rate the severity of the feeling on a scale of 1-5 (5 is most severe) _____

Do you use alcohol or drugs? □ No □ Yes

If yes, which substance? _____

If yes, how often? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

2. Name of Family Member: _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes If yes, for how long? _____

Rate the severity of the feeling on a scale of 1-5 (5 is most severe) _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes If yes, how long? _____

Rate the severity of the feeling on a scale of 1-5 (5 is most severe) _____

Do you use alcohol or drugs? □ No □ Yes

If yes, which substance? _____

If yes, how often? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

3. Name of Family Member: _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes If yes, for how long? _____

Rate the severity of the feeling on a scale of 1-5 (5 is most severe) _____

Intake continued on next page…

(3rd family member cont.)

Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes If yes, how long? _____

Rate the severity of the feeling on a scale of 1-5 (5 is most severe) _____

Do you use alcohol or drugs? □ No □ Yes

If yes, which substance? _____

If yes, how often? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

4. Name of Family Member: _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes If yes, for how long? _____

Rate the severity of the feeling on a scale of 1-5 (5 is most severe) _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes If yes, how long? _____

Rate the severity of the feeling on a scale of 1-10 (10 is most severe) _____

Do you use alcohol or drugs? □ No □ Yes

If yes, which substance? _____

If yes, how often? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, child, grandmother, etc.):

Alcohol/Substance Abuse yes/no_____

Anxiety yes/no_____

Depression yes/no_____

Domestic Violence yes/no_____

Eating Disorders yes/no_____

Obsessive Compulsive Behavior yes/no_____

Schizophrenia yes/no_____

Suicide Attempts yes/no_____

Intake continued on next page…

Additional Information:

What is the primary reason for wanting therapy at this time?

_____

_____

_____

How long has the problem existed? _____

What attempts (if any) have been made to resolve these issues?

_____

_____

_____

Have there been any significant stressors for the family in the past several years? (ex. losses, divorces, births, deaths, moves, hospitalizations, and or financial problems)

_____

_____

_____

What do you consider your family's strengths?

_____

_____

_____

What do you consider your family's weaknesses?

_____

_____

_____

What would your family like to accomplish in therapy?

_____

_____

_____

Additional Information

_____

_____

_____