BALANCE BEHAVIORAL HEALTH, PLLC

FAMILY COUNSELING INTAKE QUESTIONNAIRE

____ ________________

Full Name of Person Completing Form **Today's Date**

Do you have legal custody of any children that will be in counseling? □ Yes-Sole □ Yes-Joint □ No

If no, written permission of custodial parent is required. If joint, is the other parent aware of counseling? □ Yes □ No

PRIMARY CONTACT INFORMATION

Home Address:____

Street/PO Box **City** **State** **Zip**

Is this address okay for correspondence by mail? (Y/N)? If not, provide an acceptable address below:

Alt Address:____

Street/PO Box **City** **State** **Zip**

Phone: **Home**: (___)________ **Work**:(___)__________ **Cell**:(___)___________**Email**:_____________________________

Which of these numbers are okay to use for future communications and leaving messages? Home__; Wk__; Cell__

Please provide an emergency contact should an emergency situation arise during our work together:

Name: ____ (___)_______________________

First and Last **Phone Number**

Address:____

Street/PO Box **City** **State** **Zip**

In your own words why are you seeking family counseling? Please identify the primary problem you would like to address and the impact on specific family members:

____
____
____
____
____

HOUSEHOLD INFORMATION

Please list everyone currently living in the home on the following chart starting with yourself:

Full Name	Relation to You	Date of birth (dd/mm/yyyy)	Highest education completed	School district (as applicable)
	Self			

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Please list any family members NOT currently residing in your home:

Full Name	Relation to You	Date of birth (dd/mm/yyyy)	City and state of residence

Is any member of the household currently, or previously, been:

□Using drugs
□Using alcohol
□In a support group
□In counseling
□In a treatment program
□Under medical care

□Having suicidal thoughts
□Having homicidal thoughts
□Having auditory and/or visual hallucinations
□Displaying aggressive behavior
□Having problems w/depression or anxiety
(i.e. change in sleep, appetite, concentration)

Please provide comments for any blocks checked above:
____
____
____
____
____

EMPLOYMENT
What is your employment status? □ Full-Time □ Part-Time □ Unemployed □ Disabled
If you are working, who is your employer?____
What is your job?___________________________ How long have you been in this position?__________
What is you spouse or partner's employment status? □ Full-Time □ Part-Time □ Unemployed □ Disabled
If they are working, who is the employer?____
What is their job?____________________________ How long have they been in this position?_________

LEGAL HISTORY
Please describe any legal actions (probation, custody, divorce, personal injury, etc.) you or any family member is involved with:
____
____

MEDICAL HISTORY
Please describe any medical services or treatment you or any family members are currently receiving (include any medications being taken by name, reason for them being prescribed, and dosages):
____
____
____
____

PHYSICAL OR DEVELOPMENTAL CONCERNS

Please describe any receiving treatment or special services you or any family member is currently receiving for any physical, developmental, cognitive and/or speech concerns (physical therapy, occupational therapy, IEP, etc):

____
____
____

TRAUMA HISTORY

Please list any traumatic events or losses your family has experienced in the past 6 months:

____
____
____

MILITARY AFFILIATION

Please describe any military service you or any of your family members have experienced to include rank, specialty, length of service, deployments, injuries, and combat tours of assignment

____
____

CULTURAL/ETHNIC INFORMATION

How would you describe your family's cultural/ethnic heritage?____

What other languages are spoken in the home?____

Has your family or any family member ever been deployed overseas or served in a combat zone? □ Yes □No
If yes, please describe:____
____

Does your family practice a faith-based religion or spiritual pursuit? □ Yes □ No
If yes, please describe:____
____

SPECIAL CONSIDERATIONS

Please take a moment to note any concerns you might have about process of therapy in the space below. Areas of concern might center around the following issues:

- Family members who might have difficulty coming to appointments (due to lack of mobility).
- Family members who might require special accommodation (interpreter, wheel-chair ramp).
- Family members who might be reluctant to come to appointments, at least initially.
- Close friends or extended family members that you would like to include in sessions.

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____
____

____ ____________________
Client/parent/guardian **Date**