FAMILY
HARMONY
THERAPY

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# Intake Form

Please take your time in providing the following information. The questions are designed to help me begin to understand your child and your family so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- ☐ Medical Provider: _____
- ☐ Insurance Provider: _____
- ☐ My Website: _____
- ☐ Psychology Today: _____
- ☐ Friend/Family: _____
- ☐ Other: _____

Has your child or anyone in your family previously received any type of mental health services?

- ☐ Yes
- ☐ No

If yes, which of the following:

- ☐ Psychotherapy
- ☐ Medication
- ☐ Outpatient Hospitalizations
- ☐ Inpatient Hospitalizations

If yes, please provide:
Name of provider or facility:_____
Location:_____
Dates of treatment:_____
Reason for treatment:_____

Briefly, what brings you in today

When did you begin to notice there was a problem? Within the last:

- ☐ 30 days
- ☐ 6-12 months
- ☐ 2 years

What areas of your family's life have been affected because of this problem?

Is your child or anyone in your family currently experiencing overwhelming sadness, grief or depression?

- ☐ Yes
- ☐ No

If yes, for approximately how long? _____

Is your child or anyone in your family currently experiencing anxiety, panic attacks or have any phobias?

- ☐ Yes
- ☐ No

If yes, when did your child or family member begin

experiencing this?

Please describe any major losses or traumas your child or family have experienced:

What significant life changes or stressful events have your child or family experienced recently? What would you like your child or family to accomplish out of your time in therapy?

## Family History

Please list the members of your family and close family members. Please use additional space on the back if needed

| Name | Age | Relationship | Where do they live now? | If deceased, age and cause of death |
|---|---|---|---|---|
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Who do your children live with? _____

Mother's occupation: _____

Father's occupation? _____

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 your child in the space provided (father, grandmother, uncle, etc.).

| Condition | Please circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Sexual Abuse | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |
| Obsessive Compulsive Disorder | yes/no | |
| Schizophrenia | yes/no | |
| Suicide Attempts | yes/no | |
| Other diagnosed mental health condition? | yes/no : which was--- | |

Marital Status:

- ☐ Never Married
- ☐ Domestic Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced – For how long?
- ☐ Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:

_____

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship?

- ☐ Yes – How long? _____
- ☐ No

On a scale of 1-10 (best), how would you rate your relationship? _____

## Physical Health

Please list any medications, herbs, or supplements you and your child take. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you or your child have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

| Medication/Supplement | Dosage | Condition | Date Began/Stopped |
|---|---|---|---|
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Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or Fax: _____

How would you rate your child's current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good

- ☐ Very Good

Please list any specific health problems any of your family members are currently experiencing:

How would you rate your child's current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If your child is having problems, in which phase of sleep are they experiencing issues?

Please list any other specific sleep problems your child is currently experiencing:

How many times per week do they generally exercise? _____

What types of exercise do they participate in:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

## Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?