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# FAMILY INFORMATION FORM

The purpose of this questionnaire is to obtain information about your family's present difficulties.

**General Information:**

Child/Adolescent's Name: _____ Date of Birth:_____

Members of Household: Parents'/Adult's Names:

Mother: _____ Age: _____

Occupation:_____

Father: _____ Age:_____

Occupation: _____

Children/Family members living in your home:

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Parents'/Adult's Marital Status: _____ Date(s) of Marriage (s)/Divorce/Significant Relationships:

_____

If separated or divorced, please describe your children's relationship with their other parent

_____
_____
_____

How often do the children have contact with the non-custodial parent?_____

**Current Difficulties:**

Please state in your own words the difficulties that your child/family is experiencing:

_____

_____

_____

_____

_____

_____

When did these problems begin?_____

Are there any significant events occurred at that time, or since then, which may relate to your child/family's problems?

_____

_____

_____

_____

_____

Please circle all that apply to any members of your family (place family member's initials next to the symptom):

| | | |
|---|---|---|
| Suicide attempts _____ | Can't keep a job _____ | Takes drugs_____ |
| Impulsive _____ | Compulsive _____ | Insomnia _____ |
| Drinks too much_____ | Smokes _____ | Takes risks _____ |
| Works too hard_____ | Withdraws _____ | Sexual problems _____ |
| Procrastination_____ | Nervous tics_____ | Eating problems _____ |
| Aggressive behavior_____ | Concentration problems _____ | Out of control_____ |
| Business/Financial problems_____ | Sleep problems_____ | Crying _____ |
| Fears/Phobias_____ | Temper Outbursts_____ | Disorganized thinking _____ |

# Any concerns regarding:

**Domestic Violence**

_____

_____

_____

**Physical, Psychological and/or Sexual Abuse (current or past)**

_____

_____

_____

**School problems (Does your child have an IEP or 504 Plan?)**

_____

_____

_____

**What are your goals for therapy?**

_____

_____

_____

_____

_____

**Has your family been in therapy before or received any prior professional assistance for problems?**

_____

_____

_____

**Have any family members had any psychological problems, taken psychiatric medications, been hospitalized psychiatrically, had behavioral problems, or had difficulty with the law?**

_____

_____

_____

_____

_____

_____

**Physical Health:**

Describe any significant medical problems of family members:

_____

_____

_____

_____

_____

_____

What medications (name, dosage, dates of usage), prescription or otherwise, are any family members taking?

Name:_____ Medication(s):_____

Name:_____ Medication(s):_____

Name:_____ Medication(s):_____

Name:_____ Medication(s):_____

**Any additional information you would like for me to know?**

_____

_____

_____

_____

_____

**Religion**

What would you like me to know about your child/family's participation in religious activities?

_____

_____

_____

_____

_____

**Do you want your religious beliefs incorporated into the therapy process?**

_____

_____

_____

_____

## Cultural

**What cultural/ethnic group do you include yourself in? How do you want it incorporated into the therapy process?**

_____

_____

_____

**Recreation**

**What do you and/or your child/family do for fun (e.g. hobbies, interests, activities)?**

_____

_____

_____

_____

_____

**Strengths:**
**Please describe your child and family strengths:**

_____

_____

_____

_____

_____