ME First Wellness Professional Counselling

Family Intake Form

(use back of page if you need more room)

Name of Parent(s) requesting service:

____

(Last) (First) (Middle Initial)

____

(Last) (First) (Middle Initial)

Dates of Birth: ______________________/________________________

Ages: ________________/__________________

Address: _____________________________________ Postal Code: _______________________

Address: _____________________________________ Postal Code: ______________________

Home phone: ___________/_____________ Cell phone: _____________/______________

Work phone: ____________/_____________

Messages ok? [] Yes []No At which numbers?

Emergency contact and phone number : ____

Family Physician of children: ___________________

Referred by: ___________________________ ______________________________

Marital Status of Parents: ____

If re-married or re-partnered, please list new partners names

here:____

Children(s)'s Name(s) and Age(s):

____

____

____

____

What is your primary reason for seeking counselling at this time?

____
____
____

How long has this been a concern? ____

What help or supports have you already tried for this concern?

____
____
____

What are your family goals for counselling?

____
____

What are your family coping mechanisms?

____
____

What are your family strengths?

____
____

What are your family interests (ie. Things your family does for fun and relaxation)?

____
____
____

Indicate which items any member of your famlily experiences, by checking beside the relevant items and placing the person's initial behind the item as well.

_____Anxiety

_____ Distracted/forgetful

_____ Substance Use

_____ Pain (headaches, stomachaches, etc.)

_____ Startle easily

_____ Accident prone

_____ Difficulties with organizing, planning

_____ Avoidance behaviour

_____ Attraction to dangerous situations

_____ Thrill seeking

_____ Concentration difficulties

_____ Irritability

_____ Disrupted eating patterns

_____ Mood swings

_____ Digestive problems

_____ Sensitivity to light and/or sounds

_____ Recurring dreams or nightmares

_____ Hyperactivity/restlessness

_____ Emotionally subdued

_____ Aggression

_____ Feelings of shame and/or guilt

_____ Exaggerated emotions

_____ Self-harming behaviors (cutting, scratching, burning)

_____ Suicidal thoughts or attempts

_____ Other (please specify) ____.

_____ Stress

_____ Lethargy/exhaustion

_____ Sleep difficulties

_____ Excessive worry

_____ Coordination difficulties

_____ Easily overwhelmed

_____ Panic attacks

_____ Depression

Is any member of the family currently being treated for any medical or physical conditions? [] Yes[] No

If yes, please identify the condition, any medications, and check any boxes below which are applicable to identify who is involved in this treatment.

Person(s) being treated: ____

Condition(s): ____

Medications: ____

Involved in treatment:

❑ physician ❑ homeopath ❑ massage therapist

❑ naturopath ❑ chiropractor ❑ physical therapist

❑ acupuncturist ❑ other : ____________________________________

(Use back of page if more room is necessary for explanations)

History:

Which of the following have members of your family experienced? Check all that apply; use person's initials behind the item to indicate which person has experienced whichissue.

❑ Fetal distress

❑ Birth trauma

❑ Near drowning/suffocation

❑ Falls

- ❑ Premature birth
- ❑ Broken bones
- ❑ Major injuries or burns
- ❑ Prolonged immobilization (casts, braces, etc.)
- ❑ Surgery
- ❑ Life threatening or severe illness
- ❑ Loss of possessions (robbery, disaster, et cetera)
- ❑ Divorce/separation (as child or adult)
- ❑ Auto/bike accidents
- ❑ Poisoning
- ❑ Death of significant individual
- ❑ Witness to violence
- ❑ Abuse (verbal, physical, sexual)
- ❑ Other. Please list ____.

I understand that the treatment given is not a substitute for medical or psychological diagnosis. The practitioner does not diagnose conditions, nor prescribe or perform medical treatment.

Signature:___________________________________

____

Witness: ____________________________________

Date: _______________________________________