2209 E Market St
York, PA 17402
Phone: (717)759-1024

Intake Form- Family Therapy

Please complete this form to the best of your knowledge and ability. These questions are designed to help your therapist prepare for sessions. Please know that all content shared on this intake form will be held confidential and not shared without your consent. If there is anything that you wish to not share, leave those questions blank. If there are any questions that do not pertain to you, please mark that as N/A and move to the next.

Information on family members participating in therapy

Name (Parent)_____ Date of Birth _____

Phone Number_____ Lives with Child/ren Yes ( ) No ( )

Can a voicemail be left on this phone number? Yes ( ) no ( )

Preferred Pronouns_____ Gender_____

Occupation _____ Working Hours _____

Name (Parent)_____ Date of Birth _____

Phone Number_____ Lives with Child/ren Yes ( ) No ( )

Can a voicemail be left on this phone number? Yes ( ) no ( )

Preferred Pronouns_____ Gender_____

Occupation _____ Working Hours _____

Are both parents participating in therapy biological to the children? yes ( ) no ( )

Are the biological parents married ( ) divorced ( ), separated ( ) or deceased ( )

Is there a custody order? Yes ( ) no ( )

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If yes, please explain the custody is in the order? _____

_____

How would you describe the relationship between parents / caregivers? _____

_____

Are parents / caregivers at risk of splitting up? Yes ( ) No ( ) Unsure ( )

Please explain _____

Please provide name and age of any stepparents or other supporting caregivers _____

_____

_____

Do stepparents reside in the home with the child/ren? yes ( ) no ( )

Name (Child)_____ Date of Birth _____

Preferred Pronouns_____ Gender_____

Name (Child)_____ Date of Birth _____

Preferred Pronouns_____ Gender_____

Name (Child) _____ Date of Birth _____

Preferred Pronouns_____ Gender_____

If there is additional space needed, please use the lines below for additional family therapy participants.

_____

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_____

_____

Address _____

Who lives at the provided address? (name and age) _____

_____

Do the children spend time in another home? Yes ( ) No ( )

If yes, who do they reside with (name) and where is the home? _____

Is there a religion consideration that you would like the therapist to know about Yes ( ) No ( )

If yes, please explain _____

Emergency Contact (name & number) _____

How did you find Therapeutic Family Connections? _____

Are there any special needs that should be noted? Hearing aid devices, interpreter, mobility assistance, ect.?

_____

Presenting Problems

Current level of stress in the home

No Stress Moderate Stress High Stress

1 2 3 4 5 6 7 8 9 10

What are the **strengths** of your family? _____

_____

_____

_____

_____

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Has anyone been to therapy before and what was your experience like? (With whom, when and outcome)

_____

_____

_____

_____

_____

Can Therapeutic Family Connections collaborate with any **current** or **past** therapists? Yes ( ) no ( )

What are the areas of concern? What brings you to therapy? _____

_____

_____

_____

_____

When did these concerns begin? _____

How has each family member been affected by the presenting problem? _____

_____

_____

_____

_____

Check any treatment plan objectives.

	Conflict Resolution		Increase Emotional Support
	Consistent Household Rules		Poor Boundaries
	Decrease Reoccurring Conflict		Problem Solving
	Develop Coping Skills		Repair Strained Relationships
	Discipline		Respect
	Emotional Regulation		Strengthen Bond
	Improve Communication		Strengthen Relationships
	Increase Quality Time		

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Are there any additional treatment plan objectives? _____

_____

What has been tried to address the presenting problem?_____

_____

_____

_____

_____

Whose idea was it to come to therapy? _____

What are some significant events that have happened in your families' lives? _____

_____

_____

_____

_____

Has there been any recent changes or transitions. If so, please explain _____

_____

_____

_____

_____

Trauma History

Has any of the family members participating in therapy ever experienced any of the following? Circle all that apply.

Emotional Abuse	Sexual Abuse	Domestic Violence
Physical Abuse	Neglect	Caregiver Abuse
Verbal Abuse	Witnessed Abuse	

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Please explain any of the _____
above

_____

_____

_____

_____

Was treatment for any of the experienced trauma received? If so, where, from whom, and when?

_____

_____

_____

What was the outcome of the treatment? _____

_____

_____

_____

Are you currently safe? ( ) yes ( ) no

Mental Health History

Please check off any symptoms that apply and the severity within the last two weeks. Any symptoms that may have been missed can be explained in the spaces below. Please mark the symptoms with the family members' initials that have experienced them.

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Symptoms you have experienced within the last **two weeks**	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	Symptoms you have experienced within the last **two weeks**	**Mild** several days	**Moderate** More than half the days	**Severe** Nearly every day
Aggression toward others				Indecisiveness			
Aggression toward animals				Infidelity			
Anger				Isolated			
Anxiety				Legal Issues			
Avoidant Behaviors				Lonely			
Bing Eating				Lying			
Compulsive Behaviors				Manipulative			
Crying				Memory Loss			
Controlling Behaviors				Mood Swings			
Decreased Concentration				Nightmares			
Decreased Pleasure in Doing Things				Night terrors			
Deceased Trust in others				Obsessive Thoughts			
Depression				Oppositional Defiance			
Drug / Alcohol Use				Overeating			
Enuresis / Encopresis				Panic Attacks			
Fear				Physical Fighting			
Feeling like a Burden				Physical Pain			
Feeling Worthless				Poor Self-Esteem			
Financial Problems				Pornography			
Fire Setting				Post-Partum Depression			
Flashbacks				Purging Food			
Gambling				Racing Heart			
Grandiose Thoughts of self				Relationship Difficulties			

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Hallucinations				Restricting Food			
Headaches				Risk Taking			
Hearing Voices				Self-Harm Behaviors			
Hoarding				Sexual Dysfunction			
Homicidal Ideation				Sexual Identity Confusion			
Difficult Impulse Control				Sexual Promiscuity			
Increase in Stress							
Increased Irritability							

Please explain any of your answers _____

_____

_____

_____

_____

Please circle the number that indicates how motivated you/your family is for change.

Minimally Motivated Moderately Motivated Highly Motivated

1 2 3 4 5 6 7 8 9 10

Has anyone in your family ever been diagnosed and treated for any of the following? If so, who?

Alcohol abuse_____

Anxiety _____

Bipolar disorder _____

Depression _____

Intellectual disabilities _____

Eating Disorders _____

Panic Attacks _____

Personality Disorder _____

Post Traumatic Stress Disorder_____

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Substance abuse_____

Has anyone in your family ever taken psychiatric medications. If yes, who took what medications and how effective was treatment? _____

_____

_____

_____

_____

Please provide the names of any additional support that are involved in your life. _____

_____

_____

_____

_____

Substance Use

Has anyone in the family ever used any of the following substances? If yes, please put their initials next to the substances.

Alcohol
Caffeine
Crack/ Cocaine
Ecstasy
Heroin
Inhalants
Marijuana
Methamphetamines
Nicotine Vape
Painkillers- Not prescribed
PCP/LSD
Prescription Pills
Sleeping Pills
Stimulants

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Steroids
Tobacco

When was the last time there was substance use and what substance was it? _____

Please indicate any current or past treatments. Please use the initials of the family member in the yes category for the individual that used the substance

Yes	No	Treatment	When	Were	Outcome
		Drug/Alcohol Treatment			
		Family Based Therapy			
		Outpatient Therapy			
		Partial Hospitalization			
		Psychiatric Hospitalization			
		Support Groups			

Additional space for other treatments that are not listed _____

_____

_____

_____

Any **past** or **current** thoughts/plans/acts/ideation or intention of suicide? Please explain or write N/A if it does not apply. _____

_____

_____

_____

_____

Any **past** or **current** thoughts/plans/acts/ideation or intention of homicide? Please explain or write N/A if it does not apply. _____

_____

_____

_____

_____

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Any **past** or **current** thoughts/plans/acts/ideation or intention of self-harm? Please explain or write N/A if it does not apply. _____

_____

_____

_____

_____

Has anyone in your social circle or family ever died by suicide? If yes, please explain. _____

_____

_____

_____

_____

Parenting and Relational Style

Looking at the graph below **(**Baumrind, Maccoby&Martin,1983) how would you describe each parent's parenting style? It can be a mix of more than one. _____

_____

_____

_____

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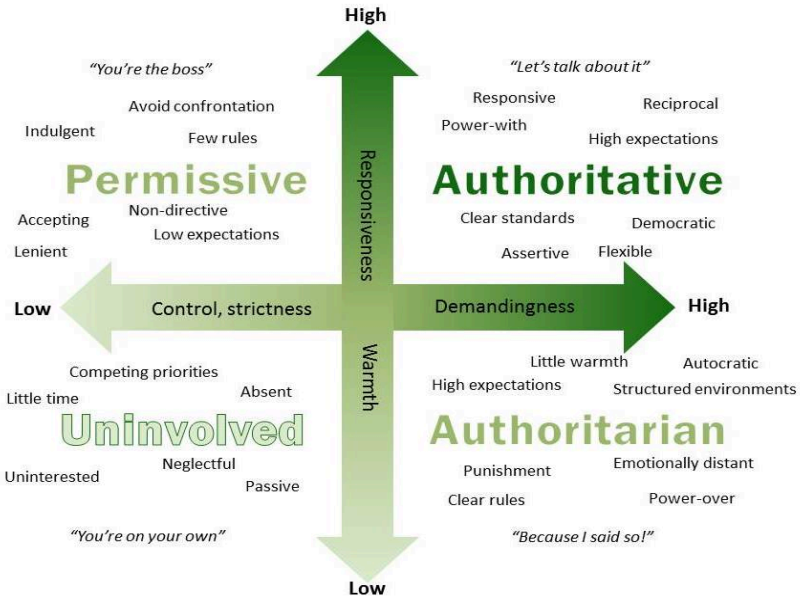

How similar or different are the parenting approaches in your family? _____

_____

_____

_____

_____

What parenting challenges are you currently facing? _____

_____

_____

_____

_____

How does your family typically communicate with each other? _____

_____

_____

_____

_____

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How does your family resolve conflict? _____

_____

_____

_____

Are there any reoccurring conflict topics? _____

_____

_____

_____

_____

What topics are easy and difficult to discuss in your family? _____

_____

_____

_____

_____

How do family members express disagreements or conflicts with each other? _____

_____

_____

_____

_____

Quality Time and Coping Skills

How does your family spend time together? _____

_____

_____

_____

_____

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How often do you spend time together as a family? _____

What activities would you like to do more as a family? _____

What prevents your family from spending quality time together? _____

What strategies do individual family members use to manage stress and difficulties? _____

What would help your family cope better with current challenges? _____

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Any additional information that would be helpful for your therapist to know? _____

_____

_____

_____

_____

By signing below, you are attesting that the above information is completed to the best of your ability. Your signature also consents to treatment for adults and child/ren in the family.

Signature _____ Date _____

Signature _____ Date _____

Guardian Signature (If under 18) _____ Date _____

Therapist Signature _____ Date _____