Family Background Information

(This is to be filled out by either individuals OR Multiple people if applicable)

Today's Date___________

Name(s)_________________________________ **Referral Source:**____________________

Address__________________________ Home Phn: _______________________OK to leave msg? Y/N

________________________________ Cell Phn(s):________________________ OK to leave msg? Y/N

Date(s) of Birth_____________________ EMAIL: ________________________________

Occupation(s):______________________________TEXTING: can we text to your cell phone? Yes No

Total Household income___________ Highest Grade of Education_____________________

Place(s) of Employment:___________________________________ City(ies)_______________________

Relationship Status: Single__ Married__ Divorced__ Cohabitating__ Widowed__

How Long?____

Previous Marriages: (please give number, year married, year divorced or widowed):____________________

1. Please list the name, sex and birthdates of those living in your home besides yourself(ves). This would include children, spouses, partners and/or any relatives.

Name	Sex	Date of Birth

PRESENT LIFE:

2. Please indicate all that apply for yourself(ves). If there are two of you filling this out this form use check marks and circles. Therefore,____________ will circle, and _____________ will checkmark (if individual simply checkmark). Also, please indicate with a square any issues that you are aware people in your current household are currently experiencing. When you are squaring and/or circling please square or circle the entire word or phrase. If you are a parent filling this out for you child simply check off what you are concerned about and circle anything that you know is present in the home.

__Threats of killing or hurting self __Any kind of reference to killing or hurting self

__Threats of killing someone else __Any kind of reference to killing someone else

__Hear or see things others do not __Self injury __Fire Setting __Arrests

__Exposure to traumatic event __Bed wetting __Stealing __Argumentative

__Avoidance of responsibility __Secretive __Irritable mood __Racing thoughts

__Over-tired or easily fatigued __Eating Problems __Muscle Tension __Hurting animals

__Unable to keep friends __Day wetting __Worry a lot __Tearful

__Pre-occupation with sex __Angry mood __Vandalism __Lying

__Frequent physical complaints __Nightmares __"Flash-backs" __Blames others

__Appetite issues __Lots of energy __Sexual difficulty __Repetitive Behaviors

__Exaggerated sense of worth __Hopelessness __Helplessness __Drug/alcohol abuse

__Mood goes up and down a lot __Frequent conflict __Fearful __Poor decisions

__Sad most of the time __Delinquency __Night terrors __Extreme shyness

__Strong sense of right and wrong __Spiritual problem __Weight problem __Lack confidence

__Tics/other involuntary movements __Interrupting others frequently __Acting without thinking

__Not interested in things __Recurring thoughts __Hard to remember things

__Hard to concentrate __Difficulty sleeping __Hair pulling

__Prescription drug abuse __Domestic Violence __Soft Pornography

__Hard Pornography __Internet relationship(s) __Infidelity/Affair

Life As I feel it:

3. **Relevant Life Experience:** Please indicate all that apply using circles, checks and squares.

__Adoption __I've "lost time" in the last month __ Excessive fears

__I feel numb at times __I have questioned my surroundings __I've felt out of place

__It seems what's happening around me is not real __If I have a bad thought I get nauseous

__My friends would say I'm "checked out" __Unwanted thoughts __I regularly feel "keyed up"

__I have hit my head and blacked out __I blacked out without head injury __I've lost consciousness before

__I have wondered who I am before __I have not recognized myself in the mirror

__I have small memory fragments that make me anxious __I've woke up and not know how I got there

__I don't like old men/women __I am only attracted to older men/women __I have a bad memory

__I spend a lot of time avoiding unwanted thoughts __I don't remember my childhood

__I have had weird memories/thoughts while having sex __I am easily startled

4. **Experiential History:** Using the same system of checkmarks circles and squares; please indicate all that apply regarding growing up in your family of origin.

__Death in the family __Unemployment __Financial stress __Crime Victim

__Basic needs not met (food/shelter/clothes) __Violence in home __Frequent moves __Natural disaster

__Living in constant fear __Legal/Court issues __Emotional abuse __ Parental Divorce

__Strong feelings of guilt or shame __Weight issues __Parental/Guardian separation

__Lived in combat zone __Been attacked with gun/knife/other __Sudden Life Threatening illness

__Family member with significant long-term illness

__Alcohol or drug abuse (indicate by whom and when):____

__Sexual or physical abuse (indicate by whom and when):______________________________________

__Known family history of physical or sexual abuse:____

5. Overall you would describe your family-life growing up as: (please use circles and checks only)

__Supportive __Loving __Chaotic __Confusing __Affirming

__Strict __Hostile __Safe __Unsafe __Negative

6. Who could you count on while you were growing up no matter what?

__Mom __Dad __Guardian __Brother __Sister __Uncle

__Aunt __Grandma __Grandpa __Cousin __Friend

7. Growing up who did you feel safe with? **Circler:** **Checker:**

8. Who was the disciplinarian in your family? **Circler:** **Checker:**

9. What was the usual form of discipline(indicate all that apply even if it only happened once)?

__Grounding __Time Out __Spanking (Circle: **with** or **without** objects) __Sent Away

__Hitting/slapping (Circle: **with** or **without** objects) __Locked in room __Other:_______________

10. How did your family solve conflict (indicate all that apply even if it only happened once)?

__Yelling __Screaming __Pushing/shoving __Talking/Listening __Ignoring people

__Ignoring Issues __Isolating (silent treatment) __Hitting/Kicking __Poking/finger thumping

11. Have you or any members of your immediate family or close friends ever seriously considered or attempted suicide? If so, please explain. **Circler:**

Checker:

12. Are you or any of your immediate family members currently taking any medications? If so, please list the medication, purpose, and prescribing physician. **Circler:**

Checker:

13. Take a moment to describe any of the above circles or checks that you feel might need some explanation such as your view point on alcohol use, internet relating, traumatic events, etc.

Circler:___ ____

____

____**Checker:**__________________________

____

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14. Do you regularly exercise? Please specify.

15. Please describe yourself spiritually. By this I am not asking for theology but merely how your spirituality takes shape and affects your general life and/or daily life.

 Circler:____

 ____

 Checker____

 ____

16. Describe what is causing you the most stress and/or concern at this time. **Circler:**

Checker:

17. As specifically as possible, what are your expectations of counseling? **Circler:**

Checker:

18. Do you have any concerns about the counseling process? **Circler:**

Checker:

19. Have you received copies of the counseling services brochure and Professional Disclosure Statement?________
20. Do you understand the "payment for services" portion of the Professional Disclosure Statement?________
21. Do you understand that your counselor ***will not*** be available for crisis intervention or emergencies, and have you been informed of where to call if you have an emergency?________

22. Is there anything further that you feel you would like to explain or add to any of the above?

I have done my absolute best to answer these questions honestly and as complete as possible.

______________________________	______________________________
Signature	Signature
______________________________	______________________________
Signature	Signature