FAMILY DATA FORM

Name: Today's Date:__________________

Referred by: ____

I would like to contact this person to thank them for the referral. Would that be ok? (circle: Yes / No)

CONTACT INFORMATION:

MAIN FAMILY CONTACT: ____

Phone: ___________________________________ Email: ____________________________________

Home Address:

Street_______________________________ City/State___________________ Zip code__________

Telephone #'s: Home___________________ Work___________________ Cell_________________

May I call you and leave a message on your home phone? __No __Yes

May I call you and leave a message on your work phone? __No __Yes

FAMILY INFORMATION:

Last__________________________ First___________________ MI_______ (Circle: PARENT / CHILD)

Date of Birth___________ Age ___ Gender (circle): M F

Last__________________________ First___________________ MI_______ (Circle: PARENT / CHILD)

Date of Birth___________ Age ___ Gender (circle): M F

Last__________________________ First___________________ MI_______ (Circle: PARENT / CHILD)

Date of Birth___________ Age ___ Gender (circle): M F

Last__________________________ First___________________ MI_______ (Circle: PARENT / CHILD)

Date of Birth___________ Age ___ Gender (circle): M F

Last__________________________ First___________________ MI_______ (Circle: PARENT / CHILD)

Date of Birth___________ Age ___ Gender (circle): M F

Last__________________________ First___________________ MI_______ (Circle: PARENT / CHILD)

Date of Birth___________ Age ___ Gender (circle): M F

EMERGENCY CONTACT:

Name___________________________ Phone #_________________ Relationship_________________

Name___________________________ Phone #_________________ Relationship_________________

ADOPTION INFORMATION:

Please note the country/countries that your child/children were adoption from, the corresponding dates, and any additional information that you think would be useful for me to know.

Why are you seeking psychotherapy?

What is your goal for this period of therapy?

CHILD INFORMATION:

School: _____ Grade: ____ Special Ed:_____
School: _____ Grade: ____ Special Ed:_____
School: _____ Grade: ____ Special Ed:_____
School: _____ Grade: ____ Special Ed:_____

Please list any previous mental health services including hospitalizations in the space below:

Therapist/Doctor Dates Reason for treatment

Please list all medications your child currently uses:

Name of Medication Dosage Prescribed by

Please check any of the following that currently apply to your child / childern:

__Nightmares __Poor school performance __Depressed __ Eating problems __Lies __Lonely __Suicidal thoughts __Worthless feelings __Homicidal ideation	__Indecisive __Truancy __Hyperactive __Low self-esteem __Poor attention __Perseverates __Auditory Hallucinations __Angry __Unable to make friends	__Racing thoughts __Forgets easily __Pregnant __Anxious __Excessive guilt __ Drug use __Sex Abuse __Visual Hallucinations __Sleeping problems	__Stealing __Negative body image __Isolates __Self-injury (i.e. cutting) __Running away __Fire setting __Harming animals

Please add anything missing from the above:

Your Signature(s): _____