

## 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 _____	Wrk Phn(s): _____ OK to leave msg? Y/N
Occupation(s): _____	Total Household income _____
Highest Grade of Education _____	
Place(s) of Employment: _____	City(ies) _____
Relationship Status: Single__ Married__ Divorced__ Cohabiting__ 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.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Threats of killing or hurting self | <input type="checkbox"/> Any kind of reference to killing or hurting self |  |   |
| <input type="checkbox"/> Threats of killing someone else    | <input type="checkbox"/> Any kind of reference to killing someone else    |  |   |
| <input type="checkbox"/> Hear or see things others do not   | <input type="checkbox"/> Self injury                                      | <input type="checkbox"/> Fire Setting            | <input type="checkbox"/> Arrests              |
| <input type="checkbox"/> Exposure to traumatic event        | <input type="checkbox"/> Bed wetting                                      | <input type="checkbox"/> Stealing                | <input type="checkbox"/> Argumentative        |
| <input type="checkbox"/> Avoidance of responsibility        | <input type="checkbox"/> Secretive  | <input type="checkbox"/> Irritable mood          | <input type="checkbox"/> Racing thoughts      |
| <input type="checkbox"/> Over-tired or easily fatigued      | <input type="checkbox"/> Eating Problems                                  | <input type="checkbox"/> Muscle Tension          | <input type="checkbox"/> Hurting animals      |
| <input type="checkbox"/> Unable to keep friends             | <input type="checkbox"/> Day wetting                                      | <input type="checkbox"/> Worry a lot             | <input type="checkbox"/> Tearful              |
| <input type="checkbox"/> Pre-occupation with sex            | <input type="checkbox"/> Angry mood                                       | <input type="checkbox"/> Vandalism               | <input type="checkbox"/> Lying                |
| <input type="checkbox"/> Frequent physical complaints       | <input type="checkbox"/> Nightmares                                       | <input type="checkbox"/> "Flash-backs"           | <input type="checkbox"/> Blames others        |
| <input type="checkbox"/> Shortness of Breath                | <input type="checkbox"/> Lots of energy                                   | <input type="checkbox"/> Sexual difficulty       | <input type="checkbox"/> Repetitive Behaviors |
| <input type="checkbox"/> Exaggerated sense of worth         | <input type="checkbox"/> Hopelessness                                     | <input type="checkbox"/> Helplessness            | <input type="checkbox"/> Drug/alcohol abuse   |
| <input type="checkbox"/> Mood goes up and down a lot        | <input type="checkbox"/> Frequent conflict                                | <input type="checkbox"/> Fearful                 | <input type="checkbox"/> Poor decisions       |
| <input type="checkbox"/> Sad most of the time               | <input type="checkbox"/> Delinquency                                      | <input type="checkbox"/> Night terrors           | <input type="checkbox"/> Extreme shyness      |
| <input type="checkbox"/> Strong sense of right and wrong    | <input type="checkbox"/> Spiritual problem                                | <input type="checkbox"/> Weight problem          | <input type="checkbox"/> Lack confidence      |
| <input type="checkbox"/> Tics/other involuntary movements   | <input type="checkbox"/> Interrupting others frequently                   | <input type="checkbox"/> Acting without thinking |   |
| <input type="checkbox"/> Not interested in things           | <input type="checkbox"/> Recurring thoughts                               | <input type="checkbox"/> Hard to remember things |   |
| <input type="checkbox"/> Hard to concentrate                | <input type="checkbox"/> Difficulty sleeping                              | <input type="checkbox"/> Hair pulling            |   |
| <input type="checkbox"/> Prescription drug abuse            | <input type="checkbox"/> Domestic Violence                                | <input type="checkbox"/> Soft Pornography        |   |
| <input type="checkbox"/> Hard Pornography                   | <input type="checkbox"/> Internet relationship(s)                         | <input type="checkbox"/> Infidelity/Affair       |   |

### ***GROWING UP:***

3. **Developmental History:** Please indicate all that apply using circles, checks and squares. To the best of your ability indicate what you know about growing inside your mother's tummy and then also birth to 3 years old.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Pregnancy Difficulties/abnormalities   | <input type="checkbox"/> Medication during pregnancy   | <input type="checkbox"/> Excessive fears             |
| <input type="checkbox"/> Walking/gross motor problems           | <input type="checkbox"/> Difficulties during pregnancy | <input type="checkbox"/> Difficult to comfort        |
| <input type="checkbox"/> Alcohol/illegal drugs during pregnancy | <input type="checkbox"/> Speech/Language Problems      | <input type="checkbox"/> Eating non foods            |
| <input type="checkbox"/> Hand coordination/fine motor problems  | <input type="checkbox"/> Overly social/friendly        | <input type="checkbox"/> Exposure to lead            |
| <input type="checkbox"/> Poor attachment to parents/caregivers  | <input type="checkbox"/> Problems eating as a baby     | <input type="checkbox"/> Problems sleeping as a baby |
| <input type="checkbox"/> Did not meet developmental milestones  | <input type="checkbox"/> Medication during pregnancy   | <input type="checkbox"/> Overweight at birth         |
| <input type="checkbox"/> Away from parents for a long time      | <input type="checkbox"/> Premature birth               | <input type="checkbox"/> Underweight at birth        |

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       Parental illness       Emotional abuse       Parental Divorce  
 Strong feelings of guilt or shame       Weight issues       Parental/Guardian separation  
 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. Have you or any of your family members ever had any type of counseling before? If so, please list the dates, with whom, and for what purpose.      **Circler:**

**Checker:**

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

**Checker:**

8. 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:**

9. 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:** \_\_\_\_\_

10. Do you eat balanced meals regularly?

11. Do you regularly exercise? Please specify.

12. 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** \_\_\_\_\_

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

**Checker:**

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

**Checker:**

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

**Checker:**

16. What is the best part of your current life? **Circler:**

**Checker:**

17. What are your greatest accomplishments? **Circler:**

**Checker:**

18. Are you involved in any service, church, or charitable work? **Circler:**

**Checker:**

19. What are your most urgent goals? **Circler:**

**Checker:**

20. Have you received copies of the counseling services brochure and Professional Disclosure Statement? \_\_\_\_\_

21. Do you understand the “payment for services” portion of the Professional Disclosure Statement? \_\_\_\_\_

22. 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? \_\_\_\_\_

23. 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