Family System Intake

Child

Adam Woodruff, MS, LMFT, CAC II
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This form requests information about your needs and informs you of my services and policies. Please take a few moments to complete this form. The questions on the following pages are designed to help me best meet your treatment needs. If the person seeking care is a minor, the parent or guardian should complete this form. If you have any questions, I will be happy to answer them.

Client Name _____ **Birth date** _____

Address _____ **Age** _____

City, State, Zip _____ **Gender: M F**

Primary Care Physician _____**Phone: (____)** _____

Mother's Cell #: (____) _____ **Work #: (____)**_____

Home: OK to contact there? Y N
OK to leave detailed msg.? Y N

Work: OK to contact there? Y N
OK to leave detailed msg.? Y N

Father's Phone # (____) _____ **Work #: (____)**_____

Home: OK to contact there? Y N
OK to leave detailed msg.? Y N

Work: OK to contact there? Y N
OK to leave detailed msg.? Y N

Mother's Email: _____

Father's Email: _____

Please list all persons living in the household:

Name Age	Relationship	Characteristics of interactions with identified client or family as a whole. (ex. Fight, get along well, ignores, blames, etc.)

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If parents are divorced (provide copy of divorce decree to therapist):

A. With whom does the child live? _____
Name **Relationship**

(If joint custody): _____
Name **Relationship**

B. Who has legal custody? _____
Name **Relationship**

C. Type of custody: _____

D. Visitation arrangements: _____

E. Parenting Coordinator (Decision Maker) _____

Please describe your reason(s) for seeking treatment. If there was an event which triggered your decision to seek treatment now, please list the event.

_____

_____

_____

What result(s) do you expect from treatment?

_____

_____

_____

_____

Medications:

Med./Dose	Past/	Effectiveness	Prescribing Physician and

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	current		**phone**

Are there any cultural, ethnic or religious factors or needs related to treatment? No Yes:

PLEASE LIST PREVIOUS OR CURRENT THERAPIES AND/OR COUNSELING THAT YOUR CHILD HAS RECEIVED.

THERAPIST'S NAME	DATES	RESULTS

REASON(S) FOR THERAPY:

FAMILY: DRUG/ALCOHOL HISTORY Identify each family member's level of substance use per chemical: rating it from O (abstinence) TO 5 (problematic). SUBSTANCES INCLUDE ALL MOOD ALTERING DRUGS (PRESCRIBED, OVER-THE-COUNTER OR ILLICIT) SUCH AS: ALCOHOL, COCAINE, LSD, MARIJUANA, TRANQUILIZERS, AMPHETAMINES, DIET PILLS, SLEEPING PILLS, ANTIDEPRESSANTS, TOBACCO, ETC...

FAMILY MEMBER	SUBSTANCES USED	LEVEL OF USE
CHILD		
SPOUSE/PARTNER (CURRENT)		
SPOUSE/PARTNER (EX)		

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YOUR PARENTS		
SPOUSE/PARTNER'S PARENTS		
SIBLING:		
SIBLING:		
SIBLING:		

DESCRIBE HOW YOUR CHILD RESPONDS TO DISCIPLINE. Give examples of efforts used to set limits:

DO YOU FEEL THAT HIS/HER PROBLEMS ARE AFFECTING OTHER MEMBERS IN THE FAMILY?

NO YES - IN WHAT WAYS?

BEHAVIORAL DEVELOPMENT (MOOD):

Please mark yes or no for the following behaviors regarding your child in the past or present:

	YES	NO
Depression (sad, worried, constantly unhappy)	___	___
Anxiety (nervous, tense, sometimes accompanied by physical symptoms)	___	___
Impulsive (doing without thinking of consequences)	___	___
Perfectionist (worry wart, obsessive, compulsive)	___	___
Oversensitive (feelings easily hurt)	___	___
Angry (outbursts, yelling, threatening)	___	___
Preoccupation with fires (matches, setting fires)	___	___
Apathetic (does not enjoy things)	___	___
Mood Swings (rapid shifts)	___	___
Self-abusiveness (cutting, burning, hurting self)	___	___
Suicidal	___	___

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Please describe behaviors you view in your child as positive qualities:

Is your child starting to loosen family ties? If yes, how?

RESPONSIBILITIES AND LIFE SKILLS:
Place a check mark beside life skill areas where your child may have needs.

Care of personal hygiene needs	
Care of clothes	
Necessary cooking skills	
Planning time	
Meeting recreational needs	
Chores	
Maintaining appropriate appearance	
Understanding of financial matters	
Decision Making	
Employment behavior	

BEHAVIOR: PLACE A CHECKMARK BY ANY OF THE FOLLOWING CHARACTERISTICS THAT APPLY TO YOUR CHILD:

HYPERACTIVE		**CRIES EXCESSIVELY**	
SUICIDE ATTEMPT		**NO FRIENDS**	
PANICS		**RUNS AWAY**	
TEMPER TANTRUMS		**SEXUAL PROBLEMS**	
FEARS		**SLEEP PROBLEMS**	
REPEATED ACCIDENTS		**DEFIANT**	
DAYTIME WETTING		**BITES NAILS**	

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WETS BED		**STEALS**	
BM's IN UNDERWEAR		**FREQUENT PAINS**	
PHYSICAL FIGHTS		**DESTRUCTIVE, DAMAGES PROPERTY**	
VERY SHY		**HIGHLY CONSCIENTIOUS**	
EATING PROBLEM		**SMOKES**	
SKIPS SCHOOL		**SELF-CRITICAL**	
VERY STUBBORN		**THREATENING**	
LIES			
GETS TEASED			

PRENATAL HISTORY:

At any time during the six months before your pregnancy and/or during your pregnancy did you use:

____caffeine, how many ounces per day?_____; ____cigarettes, how many per day?_____; ____alcohol, how many ounces average per day?_____; ____non-prescription medicines___; which ones?_____

prescription medicines; which ones, such as; sleeping pills, tranquilizers_____

_____

street drugs; such as heroin, cocaine, LSD, marijuana, inhalants, Meth.:_____

_____

EDUCATIONAL HISTORY:

SCHOOL	HOW DID CHILD DO (grades/socially)?
NURSERY SCHOOL	
KINDERGARTEN	
ELEMENTARY	
JUNIOR HIGH	
HIGH SCHOOL	

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CURRENT SCHOOL:

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING A LEARNING DISABILITY? No Yes

_____

Is there an IEP or a 504? No Yes (please provide copy to therapist).

At what age was it established? _____

CURRENT SCHOOL:_____

GRADE:_____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

Behavior	✓	Comments
Does child get along well in school?		
Has child ever repeated a grade? _____		
Has child ever been in special education classes?		
Does child have difficulties with schoolwork?		
Is something upsetting child and interfering with his/her school work?		
Does child need pressure to do homework?		
Has child ever been suspended or expelled from school?		
Does child want to drop out of school?		
Does child get into any trouble with classroom misbehavior?		

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SOCIALIZATION:

Does your child show problems in any of the following social areas?

Social Area	Yes	No
Communicating Effectively	Y	N
Assertiveness	Y	N
Being Aggressive	Y	N
Unwillingness to Cooperate/Share	Y	N
Problem with Authority Figures	Y	N
Taking Guidance or Constructive Criticism	Y	N
Willingness to Ask for Help	Y	N

Please describe any significant events you feel may have influenced your child's "social confidence":

FRIENDS:

	Yes	No
Does your child get along well with same age peers?	Y	N
Does your child have trouble keeping friends?	Y	N
Has your child ever hurt anyone while fighting	Y	N
Does your child prefer to be alone?	Y	N
Does your child have a close friend?	Y	N
Does your child spend most free time with older/younger children?	Y	N
Does your child date?	Y	N

IS THE BEHAVIOR DISPLAYED BY YOUR CHILD A NOTICEABLE CHANGE FROM THE BEHAVIOR HE/SHE HAS SHOWN IN THE PAST?
__NO __YES IN WHAT WAYS? FOR HOW LONG? _____

WHAT HAS BEEN DONE BY YOU OR OTHER FAMILY MEMBERS IN AN ATTEMPT TO MAKE THE SITUATION REGARDING YOUR CHILD MORE TOLERABLE?

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ARE THERE AREAS OF CONCERN THAT WERE NOT COVERED IN THIS QUESTIONNAIRE THAT YOU FEEL ARE IMPORTANT FOR YOUR THERAPIST TO BE AWARE OF SUCH AS FAMILY ISSUES, RECENT SIGNIFICANT EVENTS, ETC.?

TREATMENT PHILOSOPHY

I believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal in a time-efficient manner.

Although strategies and techniques vary from one therapist to another, basic techniques are established by professional practices. I do not employ techniques that are outside the mainstream of established therapy methods. If you ever have any questions about the nature of the treatment or anything else about your care, please don't hesitate to ask.

Typical goals of therapy are to:

*** Help you clarify problems and goals**
*** Help you see problems from a different point of view**
*** Help you discover new ways of solving old problems**
*** Encourage you to change certain behaviors or attitudes**
*** Enhance your self respect**
*** Help you to live a healthier and happier life**

I follow the Code of Ethics of the American Association for Marriage and Family Therapy. This is the primary professional organization which promotes the profession of marriage and family therapy.

EMERGENCY PROCEDURES

If you need to contact me, leave a message according to the instructions on my voicemail and your call will be returned. If an emergency situation arises, follow the emergency procedures mentioned on my voicemail and I will be contacted. I will return your call. Please use this for true emergencies and know that there may be a charge for lengthy telephone consultations. You may also always call 911 and speak to your local police.

CONSENT FOR TREATMENT

I further authorize and request that my child's treating provider carry out mental health examinations, treatment, and/or diagnostic procedures, which now or during the course of his/her care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I understand that the therapist or client(s) can terminate therapy at any time by giving notice personally, in writing or over the phone.

LIMITATION ON CONFIDENTIALITY WHEN PROVIDING THERAPY TO FAMILIES

When treating a family, I consider the family (the treatment unit) to be the 'patient/client'. For instance, if there is a request for treatment records for any or all members of the family, I will seek authorization for release of information from all members. During the course of therapy, I may see a smaller part of the treatment unit for one or more sessions. This should be viewed as part of the treatment being provided to the entire family unless otherwise indicated.

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However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This policy is intended to allow me to continue to treat the family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For example, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family during their therapy, I might be placed in a situation where I will have to terminate treatment of the family. This policy is intended to prevent the need for such a termination.

Signing below indicates you have had a chance to read and ask questions about this policy and that you are in full agreement with the policy.

Signature/Guardian **Date**

Signature/Guardian **Date**

Signature **Date**