FAMILY INTAKE FORM

1. Parent's Name: ________________________________ DOB: ________________________

   Address (City, State and Zip):____

   Marital Status:______________________________ Gender: _________________________

   Phone: H(___)________________W(___)___________________C(___)________________

   OK to say CFMW? Yes _______ No_______

   Emergency contact (name and phone #)____

2. Parent's Name: ________________________________ DOB: ________________________

   Address (City, State and Zip):____

   Marital Status:______________________________ Gender: _________________________

   Phone: H(___)________________W(___)___________________C(___)________________

   OK to say CFMW? Yes _______ No_______

   Emergency contact (name and phone #)____

3. Step Parent(s)/Guardian(s):____________________________________ DOB: _____________

   Address: ____

   City, State and Zip: _________________________Marital Status:_____________ Gender:____

   Phone: H(___)_______________ W(___)________________ C ( )________________________

   OK to say CFMW? Yes_______ No____

   Emergency Contact (name and phone #) ____

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Child's Name:________________________________ Age:_________ DOB: ________________

Child's Name:________________________________ Age:_________ DOB: ________________

Child's Name: ________________________________ Age: _________ DOB: ________________

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History of Problem

Please describe what concerns you have regarding your family:

____

____

How long has the problem existed? ____

____

____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

____

____

____

What attempts have been made to resolve the difficulties?_______________________________

____

Please check the symptoms that the family is currently experiencing. Please indicate to which family member you are referring, as well as duration, and severity.

Symptom	**Name (s)**	**How Long?**	**Severity of Symptoms**
Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			

Weight Change			
Difficulty Concentrating			
Obsessive Thoughts			
Tension and Anxiety			
Panic Attacks			
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			
Stomach Aches			
Bed Wetting			
Phobias			
Other			

Parent/Guardian Information:

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc.)?

____

____

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)

____

____

Is ex-spouse (biological parent) aware that you are bringing their children to CFMW? ☐Yes ☐No
If not, please explain.

____

____

If adopted, does child know of adoption? ☐Yes ☐No ☐N/A

What age was your child at the time of the adoption?

____

____

Parent Information:

Parent's Name: ______________________________ Age: _____ Occupation: ______________________

Employment status: ______________ Employer's name and address: ____________________________

Significant medical problems:____

Serious illnesses, accidents, or surgeries in the past: _______________________________________

Current and past psychiatric treatment or counseling: ____

____

Currently prescribed medications: ____

____

Current alcohol/drug use (amount, how often, intoxication frequency)

____

History of alcohol/drug use?____

History of arrest?____

Primary Care Physician:____

Psychiatrist:____

Parent's Name:____________________________ Age: _____ Occupation: ______________________________

Employment status: ______________ Employer's name and address: _____________________________________

____

Significant medical problems:____

Serious illnesses, accidents, or surgeries in the past:_______________________________

Current and past psychiatric treatment or counseling:______________________________

Currently prescribed medications:____

Current alcohol/drug use (amount, how often, intoxication frequency):_________________

____

History of alcohol/drug use?____

History of arrest?____

Primary Care Physician:____

Psychiatrist:____

Step-Parent/Guardian Information:

Step-parent/Guardian:________________________________ Age: _____ Occupation: ______________

Employment status: ______________ Employer's name and address: ____________________________

____

Significant medical problems:____

Serious illnesses, accidents, or surgeries in the past:____

Current and past psychiatric treatment or counseling:____

Currently prescribed medications:____

Current alcohol/drug use (amount, how often, intoxication frequency):_________________________

____

History of alcohol/drug use?____

History of arrest?____

Primary Care Physician:____

Psychiatrist:____

Child Information:

1). Name of Child:___________________________ Age:______ Child lives with:__________________

School:__________________________________ Grade:______ Teacher: __________________________

History of psychiatric treatment or counseling:____

Current or past drug or alcohol use (indicate past or present amount,
frequency)____

Significant medical problems:____

Serious illnesses, accidents, or surgeries in the past:____

Medications currently prescribed:____

Pediatrician:____

Psychiatrist:____

2). Name of Child:_________________________ Age:_______ Child lives with:________________

School:_______________________________ Grade:______ Teacher: _________________________

History of psychiatric treatment or counseling:____

Current or past drug or alcohol use (indicate past or present amount, frequency)

____

Significant medical problems:____

Serious illnesses, accidents, or surgeries in the past:____

Medications currently prescribed:____

Pediatrician:____

Psychiatrist:____

3). Name of Child:_________________________ Age:_______ Child lives with:_________________

School:_______________________________ Grade:______ Teacher: _________________________

History of psychiatric treatment or counseling:____

Current or past drug or alcohol use (indicate past or present amount,
frequency)____

Significant medical problems:____

Serious illnesses, accidents, or surgeries in the past:____

Medications currently prescribed:____

Pediatrician:____

Psychiatrist:____