



The Refuge Center
FOR COUNSELING



BANE BOW

Family Intake Form

Family Information

Please list those who will be present for counseling

Father's Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Email: _____ **Method of contact:** Phone or Email (circle one)

Age: _____ **Gender:** _____ **DOB:** _____ **Race:** _____

Religious Affiliation: _____

Employer: _____ **Occupation:** _____

Marital Status: Single Engaged Married (____years married) Separated Divorced (circle one)

Mother's Name: _____ **Phone:** _____

Address: Same as above _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Email: _____ **Method of contact:** Phone or Email (circle one)

Age: _____ **Gender:** _____ **DOB:** _____ **Race:** _____

Religious Affiliation: _____

Employer: _____ **Occupation:** _____

Marital Status: Single Engaged Married (____years married) Separated Divorced (circle one)

Children:

Name

Age

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**If children are stepsiblings or partial siblings please indicate next to their name*

Mental Health:

Has anyone in the immediate family currently or historically been suicidal? Yes No

If yes, who and when? _____

Has anyone in the immediate family been hospitalized for mental health related issues? Yes No

If yes, who and when? _____

Is anyone in the immediate family currently receiving counseling services with another professional?

Yes No

If yes, who and for how long? _____

Reasons for Seeking Family Counseling:

How would you know that your time in therapy has been successful? What would look different in your family? _____

List some strengths in your family: _____

List some weaknesses in your family: _____

How does your family deal with conflict? _____

How does your family celebrate/play together? _____

What are things that your family does together on a regular (weekly) basis? _____

How does your family deal with major life events (i.e. weddings, deaths, life threatening illnesses, job loss)? _____

Has anyone in the family ever struck, physically restrained, used violence against, or injured any person within the family? Yes No

If yes, please explain: _____

Referred by: _____

Therapist Church Physician Agency Friend Internet

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____