Family Therapy Intake Form

Family information		
	Mother	**Father**
Name		
Date of birth		
Address		
Contact information		
Occupation		
Religion		
Ethnicity		

Relationship status of parents (check all that apply):

- ☐ Married
- ☐ Living together
- ☐ Divorced
- ☐ Separated
- ☐ Never married

Length of relationship:

Family composition	Date of birth and age	Gender

Describe the reason(s) for seeking therapy:

What do you think it would take to improve the situation?

What are your greatest strengths as a family?

What are your expectations for family counseling?

Family history

Family background	**Family dynamics**

Please list any previous therapy or treatment received from other mental health professionals and briefly describe the outcome:

Is there anything else you'd like to add?

How important is it to improve your family relationship?

(Not important) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Extremely important)

Consent for family therapy	
By signing below, I/we consent to participate in family therapy with _____[Therapist name]_____. I/we understand that therapy is voluntary and confidential, except in cases of harm to self or others or as required by law. I/we agree to engage in therapy with honesty and respect, understanding that outcomes cannot be guaranteed. I/we also acknowledge financial responsibility for therapy sessions as outlined in the payment agreement.	
Mother's signature:	**Date:**
Father's signature:	**Date:**
Therapist information	
Name:	**Signature:**
License ID/number:	**Date:**