No. 01212016

Family Background Form

Complete information is needed to design and administer the best possible treatment. Please use the back pages if you require more space

Client Full Name:_____ **Email address**:_____

PrimaryAddress_____

Home Telephone:_____ C**ell Number**:_____

Primary Contact Name and Phone Number if different than name above:
:_____

You and your immediate family members

Name Age Relationship

1>

2>

3>

4>

Your Occupation(s):_____

Describe the mental health or relational problems that have compelled you to seek treatment now?

_____
_____
_____
_____

Describe any efforts you have made to solve these problems before and any previous therapy experiences

_____

_____

_____

If the presenting problem(s) got better, what would that look like?

_____
_____

Please list any mental health diagnoses you or another others intending to participate in treatment have along with any medications currently prescribed as well as the prescribing physician. List all current medications and prescribing doctors. *Use the back of this page if necessary.*
Describe:_____
_____
_____

What is your family history (going back two generations) of any mental illness including but not limited to substance abuse, ADHD, Bi-polar Disorder, Borderline Personality Disorder or depression in your family?

(use the back page if needed):
_____
_____
_____
_____

Have you or any family member ideated, attempted, or committed a suicide? If so, when? In your description please include those dates of any treatment that resulted?

Please describe:_____

Any history of anger management issues, abuse or violence within your family system? Please describe:

_____
_____
_____

Do you or any member of the family seeking treatment currently have any law enforcement matters pending such as court dates, probationary periods etc.? Please describe:

_____
_____

Name of person who completed this form

_____DATE:_____