Lillybrook
In Times of Struggle, We Are Here

ACCT#: _____

To be completed by a head of each household

Family Information

PLEASE PRINT CLEARLY

Name:_____

Today's Date:_____ **Referred by:** _____

Name of person responsible for payment of services: _____

I understand that Family Therapy is not covered by my insurance company and agree to pay fees as discussed with my therapist. _____ Initial.

<u>Your Household</u>:

Address: _____

Phone: House _____ **Cell** _____ **Work** _____

Employers of caregivers: _____

Family physician: _____

Children's Pediatrician: _____

Emergency contact(s): _____

<u>Family Members</u>

Use the space provided or attach additional sheets as needed to document family members.

	Name	**Birthdate/Age**	**Relationship**
Caregiver A			
Caregiver B			
Child 1			
Child 2			
Child 3			
Child 4			
Child 5			

What is the main reason for seeking services?

Have there been any prior attempts to solve the problem? When and where?

Have any family members experienced significant trauma, losses, or accidents?

Do any family members have significant medical problems? If yes, please describe:

Have family members had any prior contact with mental health professionals? If so when and where?

Has there been any physical, sexual, or emotional abuse suspected or reported? If so, please explain.

_____

_____

_____

_____

_____

Is child protective services involved? Yes/No

Do any family members have any legal difficulties?

_____

_____

_____

_____

_____

Is anyone in the family feeling suicidal at this time? Yes/no Within the past 6 months? Yes/no

If yes, which family member(s): _____

_____

Signature of person filling out the form _____

Date: _____

The information contained within this form will be reviewed and discussed between the family and therapist during their initial intake appointment and as needed thereafter.