GRYBA PHILLIPS
PROFESSIONAL COUNSELLING ASSOCIATES

206-912 Idylwyld Drive North **Business: (306) 934-5898**
Saskatoon SK S7L 0Z6 **Facsimile: (306) 934-5812**

Family Intake Form
(use back of page if you need more room)

Name of Parent(s) requesting service:

____
(Last) (First) (Middle Initial)

____
(Last) (First) (Middle Initial)

Dates of Birth: ____________________/______________________

Ages: ______________/________________

Address: ________________________________ Postal Code: ____________________

Address: ________________________________ Postal Code: ____________________

Home phone: _________/___________ Cell phone: ___________/____________
Work phone: __________/___________

Messages ok? Yes No At which numbers?

Emergency contact and phone number : ______________________________________

Family Physician of children: _________________
Referred by: _______________________ ___________________________

Marital Status of Parents: ____

If re-married or re-partnered, please list new partners names
here:____

Children(s)'s Name(s)and Age(s):

____

____

____

____

____

What is your primary reason for seeking counselling at this time?
____

____

How long has this been a concern? ____

What help or supports have you already tried for this concern?
____

____

What are your family goals for counselling?
____

What are your family coping mechanisms?
____

What are your family strengths?
____

What are your family interests (ie. Things your family does for fun and relaxation)?
____

____

Indicate which items any member of your famlily experiences, by checking beside the relevant items and placing the person's initial behind the item as well.

_____Anxiety
_____ Distracted/forgetful
_____ Substance Use
_____ Pain (headaches, stomachaches, etc.)
_____ Startle easily
_____ Accident prone
_____ Difficulties with organizing, planning
_____ Mood swings
_____ Digestive problems
_____ Sensitivity to light and/or sounds
_____ Recurring dreams or nightmares
_____ Hyperactivity/restlessness
_____ Emotionally subdued
_____ Aggression
_____ Feelings of shame and/or guilt
_____ Exaggerated emotions
_____ Self-harming behaviors (cutting, scratching, burning)
_____ Suicidal thoughts or attempts

_____ Avoidance behaviour
_____ Attraction to dangerous situations
_____ Thrill seeking
_____ Concentration difficulties
_____ Irritability
_____ Disrupted eating patterns
_____ Stress
_____ Lethargy/exhaustion
_____ Sleep difficulties
_____ Excessive worry
_____ Coordination difficulties
_____ Easily overwhelmed
_____ Panic attacks
_____ Depression

_____ Other (please specify) ____.

Is any member of the family currently being treated for any medical or physical conditions? Yes No
If yes, please identify the condition, any medications, and check any boxes below which are applicable to identify who is involved in this treatment.\

Person(s) being treated: ____

Condition(s): ____
Medications: ____

Involved in treatment:

❑ physician ❑ homeopath ❑ massage therapist
❑ naturopath ❑ chiropractor ❑ physical therapist
❑ acupuncturist ❑ other : __________________________________

(Use back of page if more room is necessary for explanations)

History:

Which of the following have members of your family experienced? Check all that apply; use person's initials behind the item to indicate which person has experienced which issue.

❑ Fetal distress
❑ Birth trauma
❑ Premature birth
❑ Broken bones
❑ Major injuries or burns
❑ Prolonged immobilization (casts, braces, etc.)
❑ Surgery
❑ Life threatening or severe illness
❑ Loss of possessions (robbery, disaster, et cetera)
❑ Divorce/separation (as child or adult)
❑ Other. Please list ____.
❑ Near drowning/suffocation
❑ Falls
❑ Auto/bike accidents
❑ Poisoning
❑ Death of significant individual
❑ Witness to violence
❑ Abuse (verbal, physical, sexual)

I understand that the treatment given is not a substitute for medical or psychological diagnosis. The practitioner does not diagnose conditions, nor prescribe or perform medical treatment.

Signature:__________________________________

____

Witness: ___________________________________

Date: ______________________________________