

Rhonna W. Phillips
Counseling & Therapy Services, LLC

PSYCHOSOCIAL HISTORY FOR FAMILY INTAKE ASSESSMENT

Complete prior to initial appointment. If any dependent child may be the subject of focus, also complete the CHILD/ADOLESCENT INTAKE ASSESSMENT.

Date of Intake appt: _____

Who is initiating service _____ Role _____

DOB _____ Age ____ Home Phone _____ Cell Phone _____

Address: _____

Current problem as the adult/s sees it “ _____

_____”

Current Problem as the Child/ren or Teens see it “ _____

_____”

Those who are to be present for the initial session:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

How are the above stated problems affecting others in your household or family? _____

Current Household members: Names, Adult Roles (biological parent or step, other) Siblings (biological, (1/2), step) & Ages & Date of merger _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

If Divorced, describe non-Custodial parent & those Household members:

1. _____

2. _____

3. _____

4. _____

5. _____

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Others who are closely involved ie: Grandparents, sig others... describe:

1. _____
2. _____
3. _____
4. _____

Regular visitation schedules, court orders....

1. _____
2. _____
3. _____

_____ has Legal Custody of _____
& current physical custody of _____

& _____ has Legal Custody of _____
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Any absent biological parent? Name _____ relation _____
Phone _____ Address _____

Mental Illness in any family members (Hospitalizations, RX, Depression, Anxiety, Suicide/attempts, Substance Abuse, Psychosis, Counseling..)

Biological Mother/side: _____

Biological Father/side: _____

Step Mother/side: _____

Step Father/side: _____

Legal Problems in any family members of current or related households

OFFICE NOTES: _____

Axis IV Dx Impr _____ PLAN: _____

HMWK: _____ RTC: _____

Rhonna W. Phillips, MA Date _____

Licensed Professional Counselor & Supervisor

Licensed Marriage and Family Therapist

Collaborative Practitioner

Qualified Family & Domestic Relations Mediator

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