Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, Glencoe & Litchfield

925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
www.thejonascenter.com

Family Intake

Date:_____ Name:_____ Home Phone:_____

Address:_____

Okay to leave messages/reminder calls?_____ Date of birth:_____

Marital Status:_____ Date Married:_____ Previous Marriages:_____

IMMEDIATE FAMILY MEMBERS LIVING IN THE HOME

Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*
Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*
Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*
Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*
Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*
Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*
Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*

IMMEDIATE FAMILY MEMBERS LIVING OUTSIDE THE HOME

Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*

Address

Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*

Address

Name	*Age*	*Sex*	*Date/Place of Birth*	*Race/Ethnicity*

Address

EXTENDED FAMILY INFORMATION

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Parent's Name	*Occupation/Education*	*Marriage Status*	*Age*	*If Deceased, When?*
Parent's Name	*Occupation/Education*	*Marriage Status*	*Age*	*If Deceased, When?*
Parent's Name	*Occupation/Education*	*Marriage Status*	*Age*	*If Deceased, When?*
Parent's Name	*Occupation/Education*	*Marriage Status*	*Age*	*If Deceased, When?*
Sibling's Name	*Occupation/Education*	*Marriage Status*	*Age*	*If Deceased, When?*
Sibling's Name	*Occupation/Education*	*Marriage Status*	*Age*	*If Deceased, When?*
Sibling's Name	*Occupation/Education*	*Marriage Status*	*Age*	*If Deceased, When?*

MEDICAL INFORMATION

Primary Care Physician/Clinic: _____

Address: _____

Phone: _____ Date of last exam: _____

List major health problems/disabilities/hospitalizations of family members: _____

List all current prescribed medicines with dosages of family members: _____

List any known allergies to drugs or medicines of family members: _____

List any over-the-counter medicines used regularly by family members: _____

EDUCATION/EMPLOYMENT INFORMATION

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Name	*Highest Grade Complete*	*Occupation*	*Current School/Employment Status*
Name	*Highest Grade Complete*	*Occupation*	*Current School/Employment Status*
Name	*Highest Grade Complete*	*Occupation*	*Current School/Employment Status*
Name	*Highest Grade Complete*	*Occupation*	*Current School/Employment Status*
Name	*Highest Grade Complete*	*Occupation*	*Current School/Employment Status*
Name	*Highest Grade Complete*	*Occupation*	*Current School/Employment Status*
Name	*Highest Grade Complete*	*Occupation*	*Current School/Employment Status*

Military service (date and branch) of any family members:

FAMILY STRENGTHS

What are your family's strong points, strengths and interests?

MAIN PROBLEM

What is the main problem for which you are seeking help?

How long has it been a problem?

What previous mental health treatment has been tried - Was it helpful?

Previous mental health provider(s) with address/phone (if known):

List current medicines used for emotional problems w/ dosage – Are they helpful?

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List any medicines previously used for emotional problems w/ dosage – Were they helpful?

What major stresses or changes have occurred in your life?

Include moves, job loss or changes, divorce, illnesses, deaths, trauma, legal problems, abuse issues, or alcoholism in family. Also mention major stresses for other family members, such as accidents, illnesses, job loss, etc.

CHEMICAL HEALTH INFORMATION

Has chemical use ever been a problem for any immediate family members (describe)?

Alcohol? Yes/no Who?

Cigarettes? Yes/no Who?

Caffeine? Yes/no Who?

Other drugs? Yes/no Who?

Has previous chemical dependency treatment been tried and was it helpful?

Treatment facility with address/phone (if known):

Extended family members' use of alcohol, caffeine, or other drugs:

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SYSTEM OR PROBLEM LIST

Mark each symptom below with either a yes or a no if the symptom is concerning to you:

	Yes	No		Yes	No
Depression or Sadness	___	___	Forgetfulness	___	___
Loss of Interest	___	___	Disoriented or Confused	___	___
Sleep Problems or Nightmares	___	___	Personality Changes	___	___
Appetite Changes	___	___	Hallucinations	___	___
Irritable or Short Tempered	___	___	Short Attention Span	___	___
Withdrawn	___	___	Impulsive	___	___
Fatigue or Low Energy	___	___	Cannot Sit Still	___	___
Guilty Feelings	___	___	Easily Distractible	___	___
Change in Activity Level	___	___	Binging or Purging	___	___
Headaches or Stomachaches	___	___	Excessive Concern with Appearance	___	___
Self-Harming Behaviors	___	___	Destructive or Fighting	___	___
Mood Swings	___	___	In Trouble with Law	___	___
Nervousness	___	___	Other Dangerous Behaviors	___	___
Anxiety or Panic Attacks	___	___	Family Problems	___	___
Excessive Worry or Stress	___	___	Social Problems	___	___
Negative Thoughts or Other Fears	___	___	Sexual Behaviors or Problems	___	___
Other Obsessions/Compulsions	___	___	Work or School Problems	___	___

Other concerns/comments: _____

_____

_____

Name and role of person filling out form: _____

Signature: _____ Date: _____