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## **Family Background Form**

CHILD(RENS) INFORMATION:			
CHILD'S NAME:	DOB:	AGE: _	
GRADE: TEACHER:			
ETHNIC BACKGROUND:	RELIG	RELIGION:	
CHILD'S NAME:	DOB:	AGE: _	
GRADE: TEACHER:	SCHOOL:		
ETHNIC BACKGROUND:			
CHILD'S NAME:	DOB:	AGE: _	
GRADE: TEACHER:	SCHOOL:		
ETHNIC BACKGROUND:			
ADULT(S) INFORMATION: NAME:ADDRESS:			
PHONE (HOME): (WC	ORK): (CELL)	):	
EMAIL:ETHNIC BACKGROUND:HIGHEST GRADE OF EDUCATION: OCCUPATION:	RE		
NAME:			
ADDRESS:			
PHONE (HOME): (WC	ORK): (CELL)	):	
EMAIL:			
ETHNIC BACKGROUND:	RE		
HIGHEST GRADE OF EDUCATION:			
OCCUPATION:			

(USE BACK OF FORM FOR ADDITIONAL FAMILY MEMBERS)

PARENT MARITAL STATUS: Single	Living together Engaged	
MarriedSeparated Divorced		
Number of Years married/living together		
Were there any previous marriages for e		
Additional Info/Duration/Children from		
Traditional into paration, diniar en iron	i previous relationships it applicable.	
WHO IS LIVING IN YOUR RESIDENCE?		
CHILDREN NOT LIVNG AT HOME:		
FAMILY MENTAL HEALTH HISTORY: H		
immediate family members or relatives		
following? (check any that apply and list	t family member, e.g., Sibling, Parent,	
Uncle, etc.):		
Difficultus Equality Monak	207	
Difficulty: Family Memb	Jer	
Depression: □ No □ Yes		
Bipolar Disorder:   No  Yes		
Anxiety Disorders:   No  Yes		
Panic Attacks:   No  Yes		
Schizophrenia:   No  Yes		
Alcohol/Substance Abuse:   No  Yes		
Eating Disorders:   No  Yes		
Learning Disabilities:   No  Yes		
Trauma History:   No  Yes		
Suicide Attempts:   No  Yes		
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WHY YOU'RE HERE:		
What is the problem you seek help for?	How long has it existed?	

What might contribute to the problem, i.e. the "emotional climate" in the home or community?		
Please describe previous experience with counseling including what was helpful and what was not helpful:		
Do any family members currently use substances?		
If yes please describe frequency, amount, time of first use, and any current use (within the last 30 days): Cigarettes: $\square$ No $\square$ Yes		
Caffeine:   No  Yes		
Alcohol:   No  Yes		
Street Drugs:   No  Yes		
Prescription Medication (not as prescribed by physician): $\square$ No $\square$ Yes		
Other:		
Medical/Physical Health (please check all that apply and provide further explanation and/or identify family member in the space provided):		
□ Dizziness/Fainting		
□ Epilepsy		
□ Sexually transmitted diseases		
□ Allergies		
□ Eating problems		
□ Sleeping problems		
□ Anemia		
□ Fatigue		
□ Hearing problems		
□ Heart Problems		
□ Vision Problems		
□ Autoimmune Disease		
□ Digestive Issues		

□ Neurological Issues □ Reproductive Issues □ Other Current Medications (please list both prescription and over the counter medication as well as dose, frequency, and reason for medication):
Please list and medical, mental health, or other professionals I should speak
Are there special, unusual, or traumatic circumstances that impacted family
members (past or current)?   Yes  No If Yes, please describe:
Describe Current Social Relationships:
Describe Current Social and Leisure Activities Including Frequency:
How important to you are spiritual matters? □ Not at All □ Somewhat □ Moderate □ Very Much Are you affiliated with a spiritual or religious group? □ Yes □ No If Yes, describe:
Military experience?: □ Yes □ No If Yes, describe: