

Carolyn Wolfe, LMFT, LLC
450 W Broad St #321
Falls Church, VA 22046
Telephone: (703) 405-9451

Family Background Form

CHILD(REN)S INFORMATION:

CHILD'S NAME: _____ DOB: _____ AGE: _____
GRADE: _____ TEACHER: _____ SCHOOL: _____
ETHNIC BACKGROUND: _____ RELIGION: _____

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ADULT(S) INFORMATION:

NAME: _____ DOB: _____ AGE: _____
ADDRESS: _____
PHONE (HOME): _____ (WORK): _____ (CELL): _____
EMAIL: _____
ETHNIC BACKGROUND: _____ RELIGION: _____
HIGHEST GRADE OF EDUCATION: _____
OCCUPATION: _____

NAME: _____ DOB: _____ AGE: _____
ADDRESS: _____
PHONE (HOME): _____ (WORK): _____ (CELL): _____
EMAIL: _____
ETHNIC BACKGROUND: _____ RELIGION: _____
HIGHEST GRADE OF EDUCATION: _____
OCCUPATION: _____

(USE BACK OF FORM FOR ADDITIONAL FAMILY MEMBERS)

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: No Yes _____

Caffeine: No Yes _____

Alcohol: No Yes _____

Street Drugs: No Yes _____

Prescription Medication (not as prescribed by physician): No 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 with in order to provide you with comprehensive services: _____

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: _____

THANK YOU!