Intake Form for Reunification Counseling

Name:_____ Date:_____

Address:_____ DOB:_____

City:_____ Zip:_____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ Employer: _____

Married ____ Single ____ Divorced ____ Widow/er ____

In Case of Emergency Call: _____

Relationship: _____ Phone: _____

Referred by: _____

Insurance Billing: _____ Yes _____ No

_____

Signature Date

_____

Office Use

_____

Therapist Date

Child(ren) Name(s):

Name	DOB	Grade in School
Name	DOB	Grade in School
Name	DOB	Grade in School
Name	DOB	Grade in School

1. Describe your relationship with each of the children:

2. Describe a history of your relationship with the other parent:

3. Describe your goals for counseling:

4. Describe your concerns for counseling:

5. How would you want to grow personally in this process?

6. What do you think will be the most significant challenges to achieve the stated goals?

7. What do you wish your child(ren) understood about you? How have you attempted to communicate this to each of them?