Shape, circle

Description automatically generated

**Family Therapy Questionnaire**

**To be completed by all adults**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I thank them? \_\_\_\_\_\_\_\_\_\_\_\_

Who you are in your family \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

People in your family:

Name Identity Live with you? Age Cell Phone

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Who is Head(s) of Household? Occupation & Place of Employment

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If you have children/young adults in school – grade/level - school

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Do you have pets? Names?

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What is the main reason you are seeking family therapy?

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How long have you been experiencing concerns/issues as a family?

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Which family members agree with your perspective on “what” is happening or of concern in your family?

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Which family members disagree with your perspective, if any?

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Each family has strengths and weaknesses. S for strength W for weakness

\_\_\_\_\_ communicating \_\_\_\_\_ trusting one another

\_\_\_\_\_ dealing with money/finances \_\_\_\_\_ free of addictions

\_\_\_\_\_ sharing responsibility \_\_\_\_\_ shared interests

\_\_\_\_\_ being respectful \_\_\_\_\_ ability to understand one another

\_\_\_\_\_ shared desire to be with one another \_\_\_\_\_ behaviors of care and love

\_\_\_\_\_ other (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your family received professional help prior to coming here today? If so, when, for how long, helpful?

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Are any family members in individual or couple therapy? Please specify.

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Are any family members exhibiting physical or psychological symptoms as a result of the family issues? Who and for how long?

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Do any family members have an active addiction? Please explain.

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Are any family members under a physician’s care or on medication? Please explain.

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As a family, how often do you spend time together, and what do you usually do?

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What would you really like to have happen in your family? Everyone is welcomed to respond and share. Use the back of this paper.

Please note that Dr. Suzanne Nixon does not participate with insurance companies. Payment is due at the time of service, and clients file their claims with their insurance company. If you have a PPO insurance plan, we recommend you contact your insurance company and ask for their reimbursement %. \_\_\_\_\_\_\_ Initial

Who will be responsible for payment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dr. Suzanne Nixon

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