



Wesley Center for Play Therapy Family Information



Family Information:

Questions Pertaining to the Parent's Family of Origin:

1) Were you adopted? yes no

2) Were you living with both your natural or adopted parents for most of the time from birth to High School?

yes no

If yes, how would you describe your parent's marriage?

very unhappy unhappy neither happy, nor unhappy happy very happy

3) Of the first 18 years of your life, how many years, or parts of years did you live in a home with just one adult (parent, step parent, guardian, etc.)?

0 1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16 17 18

4) If you did not live with both of your natural or adopted parents for most of the time from birth through the High School years, were you:

raised by a single parent raised by a mother and a stepfather
 raised by a father and stepmother raised by relatives or guardians
 other (specify)

5) If you were raised by a married couple other than your natural or adopted parents (example: mother and stepfather) was this marriage:

very unhappy unhappy neither happy, nor unhappy
 happy very happy

6) How many children were in the family in which you spent most of your childhood? Count step or half-siblings if they lived with you and/or were a significant part of your growing-up experience, otherwise do not count them.

0 1 2 3 4 5 6 7 8 9 10 or more

7) Starting with the oldest as number one, were you the first, second, third, etc. child in this family you described in the previous question?

0 1 2 3 4 5 6 7 8 9 10th or more

Questions pertaining to current family life style:

8) What is your religious preference?

Protestant Catholic Jewish Agnostic (not sure about the existence of God)
 Atheist (do not believe in the existence of God) none other_____

9) Do you consider yourself:

anti-religious not religious slightly religious
 moderately religious strongly religious

10) Have you had previous experience with counseling? yes no

If yes, what type and number of sessions?

Individual 1-5 6-10 10-20 21 or more

Marriage/Family 1-5 6-10 10-20 21 or more

Therapy group 1-5 6-10 10-20 21 or more

Agency: _____ Counselor: _____

11) How would you describe your reaction to counseling?

satisfied somewhat satisfied not satisfied

12) Present marital status:

single engaged living with someone married separated

divorced widowed in a committed relationship but not living with your partner

13) Number of times you have been married? 0 1 2 3 4 5 6 or more

14) Number of times you have been divorced? 0 1 2 3 4 5 6 or more

15) Age at time of first marriage: _____

16) Age at time of last marriage, if you have been married more than once: _____

17) List all of your natural and stepchildren in order of birth.

Please circle the child that will be receiving counseling.

Child 1: _____ Age: _____ M F

Child 2: _____ Age: _____ M F

Child 3: _____ Age: _____ M F

Child 4: _____ Age: _____ M F

Child 5: _____ Age: _____ M F

Child 6: _____ Age: _____ M F

Child 7: _____ Age: _____ M F

Child 8: _____ Age: _____ M F

18) Which of your children are stepchildren? Child: 1 2 3 4 5 6 7 8

19) Which of your children live with you? Child: 1 2 3 4 5 6 7 8

20) Which of your children live with another parent/guardian?

Child: 1 2 3 4 5 6 7 8

21) Which of your children live on their own? Child: 1 2 3 4 5 6 7 8

Information about the child you are bringing into counseling

22) What does your child say the problem is? _____

23) What have you done to remedy the problem so far? _____

24) Has it worked? _____

25) What have you heard from the your child's teacher or childcare provider? _____

26) Do you suspect verbal, sexual, or physical abuse? _____

Please indicate why you have come to therapy.

27) Check the box beside all the concerns that apply to your family: Family Problems

- | | | |
|---|---|--|
| <input type="checkbox"/> One or both of us not spending enough time with family | <input type="checkbox"/> Disagreement with partner about childrearing and/or discipline | <input type="checkbox"/> Emotional abuse of the child(ren) |
| <input type="checkbox"/> Poor communication among one or more family members | <input type="checkbox"/> Not sure what to expect of children | <input type="checkbox"/> Sexual abuse of the child(ren) |
| <input type="checkbox"/> One or more family member(s) does/do not get along with each other | <input type="checkbox"/> Don't feel I'm a good parent | <input type="checkbox"/> Difficulty allowing the child(ren) to grow up |
| <input type="checkbox"/> Custody or visitation problems | <input type="checkbox"/> Physical abuse of the child(ren) | <input type="checkbox"/> Other family problem(s). Please specify _____ |
| | <input type="checkbox"/> Fear of abusing the child(ren) | _____ |

28) Check the box beside all the concerns that apply to you: Adult, marital, or intimate relationship concerns

- | | | |
|--|--|--|
| <input type="checkbox"/> Career of life goals | <input type="checkbox"/> Physical problem(s)/illness | <input type="checkbox"/> Emotional abuse of/by partner |
| <input type="checkbox"/> Whether to marry | <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Physical abuse of/by partner |
| <input type="checkbox"/> Whether to have children that affect my family | <input type="checkbox"/> Employment difficulties | <input type="checkbox"/> Careers of both partners conflict |
| <input type="checkbox"/> Parenting a newborn | <input type="checkbox"/> Alcohol or drugs | <input type="checkbox"/> One partner is domineering/controlling |
| <input type="checkbox"/> Whether to separate | <input type="checkbox"/> Poor relationships with opposite sex adult (other than marital partner) | <input type="checkbox"/> We have different expectations about what marriage/an intimate relationship should be |
| <input type="checkbox"/> Whether to Divorce | <input type="checkbox"/> Religion | <input type="checkbox"/> One or both of us no longer feel in love with the other |
| <input type="checkbox"/> Being divorced or separated | <input type="checkbox"/> Intellectual differences | <input type="checkbox"/> One or both of us do not feel emotional support from the other |
| <input type="checkbox"/> Single parenting | <input type="checkbox"/> Poor communication | <input type="checkbox"/> One or both of us can't accept faults in spouse |
| <input type="checkbox"/> Being remarried | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> One or both of us are jealous of partner's relationships with opposite sexed friends |
| <input type="checkbox"/> Living in a remarried family with children | <input type="checkbox"/> Sexual identity/sexual orientation concerns | <input type="checkbox"/> Other problems with friends |
| <input type="checkbox"/> Moving/relocating | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Problems with relatives |
| <input type="checkbox"/> Addition of a relative or friend to the household | <input type="checkbox"/> Sexual Identity/sexual orientation | <input type="checkbox"/> Contact from ex-spouse upsetting our relationship |
| <input type="checkbox"/> Grief/mourning following loss | <input type="checkbox"/> Intellectual differences | <input type="checkbox"/> Relationship takes second place to the children |
| <input type="checkbox"/> Depression/feeling blue | <input type="checkbox"/> Poor communication | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Anger or difficulty controlling anger | <input type="checkbox"/> Arguing or handling conflict | _____ |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Differences in personality | _____ |
| <input type="checkbox"/> Lack of trust | <input type="checkbox"/> Infidelity or running around | _____ |
| <input type="checkbox"/> Feeling rejected | <input type="checkbox"/> Amount of time spent together | |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Use of leisure or shared activities | |
| <input type="checkbox"/> High anxiety | <input type="checkbox"/> The role of men and women | |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Domestic tasks/ who does what around the house | |
| <input type="checkbox"/> Midlife crises/problems related to growing older | | |

29) Check the box beside all the concerns that relate to the child your are bringing to counseling

Child and Teen Problems

- | | | |
|--|--|--|
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Inappropriate attention getting | <input type="checkbox"/> Sexual identity/sexual orientation concerns |
| <input type="checkbox"/> Competitiveness | <input type="checkbox"/> Destructiveness | <input type="checkbox"/> Trouble with the law |
| <input type="checkbox"/> Complaining | <input type="checkbox"/> Fire setting | <input type="checkbox"/> Misusing driving privileges |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Not following rules or curfews | <input type="checkbox"/> Problems with dating |
| <input type="checkbox"/> Talking back | <input type="checkbox"/> Running away | <input type="checkbox"/> Suicide attempt or talk of suicide |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Stealing | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Truancy from school | <input type="checkbox"/> Difficulty in response to parent's divorce |
| <input type="checkbox"/> Hitting others | <input type="checkbox"/> Academic problems | <input type="checkbox"/> Difficulty with parent's new marriage |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Poor peer relations | <input type="checkbox"/> Difficulty with divorced parents' dating |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Undesirable friends | <input type="checkbox"/> Other child/teen problem(s). Please specify |
| <input type="checkbox"/> Negativism | <input type="checkbox"/> Bedwetting | _____ |
| <input type="checkbox"/> Noisiness | <input type="checkbox"/> Pants wetting | _____ |
| <input type="checkbox"/> Not doing chores or assignments | <input type="checkbox"/> Soiling Pants | _____ |
| <input type="checkbox"/> Sadness/unhappiness | <input type="checkbox"/> Not eating properly | |
| <input type="checkbox"/> Teasing | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Excessive worrying | |
| <input type="checkbox"/> Bossiness | <input type="checkbox"/> Physical or mental disability | |
| <input type="checkbox"/> Threatening | <input type="checkbox"/> Hyperactiveness (too active) | |
| <input type="checkbox"/> Whining | <input type="checkbox"/> Drugs or alcohol | |
| <input type="checkbox"/> Yelling | <input type="checkbox"/> Sexual misbehavior or problem pregnancy | |