

**FAMILY GROUP APPLICATION**

Date: \_\_\_\_\_

NAMES OF PARENTS ATTENDING:

ADDRESSES:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DAYTIME PHONE:

\_\_\_\_\_

\_\_\_\_\_

MARITAL STATUS: M S W D

CHILDREN ATTENDING:

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

Do the children have a different address and/or phone number than the one listed above?

\_\_\_\_\_  
\_\_\_\_\_

Name/phone of someone to contact in an emergency:

\_\_\_\_\_  
\_\_\_\_\_

## Intake Information

It will help us to focus our work if you would answer the following questions. However, if you prefer not to provide this information, or would feel more comfortable sharing in person, we certainly understand. What you tell us in these forms is confidential with a couple of exceptions. If you tell us that a minor may be at risk (physical harm, emotional or sexual abuse), we are legally responsible to contact the appropriate persons to ensure a child's safety.

### PART 1 - PARENT(S)

1. What issues bring you to Choices for Change?

\_\_\_\_\_

2. What do you hope your family will gain or learn here? \_\_\_\_\_

\_\_\_\_\_

3. Is either parent an alcoholic or chemically dependent? \_\_\_\_\_

4. Has the chemically dependent person received help or treatment? \_\_\_\_\_

5. What are your concerns regarding your children? \_\_\_\_\_

\_\_\_\_\_

6. What are your strengths as a family? \_\_\_\_\_

\_\_\_\_\_

7. What do you do together as a family?

\_\_\_\_\_

8. Do family members argue a lot? \_\_\_\_\_

9. What support system is there for you outside your family? (i.e., friends, family, church, 12-step program, etc.) \_\_\_\_\_

\_\_\_\_\_

10. Is your family currently dealing with legal problems? Please describe if it pertains to our work:

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11. (NOT OPTIONAL) Do any of your children have medical problems we need to know about? (allergies, asthma, etc.)

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12. (NOT OPTIONAL) Is your child on any medication we should know about?

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**THE FOLLOWING WILL HELP US FOCUS OUR WORK WITH YOUR CHILD:**  
On the back of this sheet, briefly write about each of your children who will be coming to Choices for Change. You might want to include the following:

- a. temperament, attitude
- b. special problems or needs
- c. how your child relates to parents, siblings, peers
- d. how your child relates to any other significant adults in his/her life
- e. how your child does in school
- f. what you hope this child will gain in the next ten weeks at Choices
- g. any other information you feel would be relevant

**AUTHORIZATION TO RECEIVE AND/OR RELEASE  
INFORMATION**

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Program Coordinator for Choices for Change

has my permission to release and receive verbal and written information from and/or to the following persons for the reasons stated below. It is my understanding that I may cancel this authorization at any time. It is also my understanding that this authorization is only in effect for the length of time stated below.

PERSON	AGENCY	REASON

Length of time authorization is in effect:

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(Signature of Client)

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(Date)

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(Signature of Parent/Guardian)

Please return form to Choices for Change - ATTENTION:

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Program Coordinator for Choices for Change

To evaluate the quality and effectiveness of our program, we like to call families during the first year following their participation in Choices for Change to ask how the session has made a difference in their lives.

Please sign below if you would be willing to talk with us. We appreciate your cooperation.

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(Your Signature)