KLINGBERG
FAMILY CENTERS

Psycho-Social Information for Family Members

(This form must be completed and signed by your therapist)

Date of Exam: _____
Patient Name: _____
Address: _____

- Date you began working with this patient: _____
- If applicable, date you ended your work with this patient: _____

- What were the circumstances that led to your initial contact? _____
  _____
  _____

- Describe the initial contact (inpatient care, outpatient care, emergency care, diagnostic, exploration of possible ongoing treatment, etc.) _____
  _____

- Since your first contact with this patient, what has your relationship with them been like since?
  _____
  _____
  _____

Please list all known diagnoses that you are aware of:

Diagnoses	**Date(s) of diagnoses**	**How diagnoses affects living of patient**

Please use back of page if additional space is needed

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Please list all psychotropic medication that patient is currently taking:

Name of medication	**Who prescribes this medication**	**Dosage**	**Reason for medication**

Does this patient have any history of alcohol, drug abuse, or any other type of addiction?

- No
- Yes (please specify) _____

Please comment on this patient's emotional capacity for foster/adoptive parenting of children who have experienced loss and/or trauma:

_____
_____
_____
_____

If applicable, please discuss any involvement regarding the patient's status as disabled regarding work as a result of psychiatric diagnoses:

_____
_____
_____

Therapist's Signature: _____

Therapist's Name (Print): _____ Date: _____

Address: _____

Telephone: _____ Fax: _____