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COUPLES INFORMATION FORM

Today's Date: ______________________________

Name: ____________________________________

Address: ____

Telephone: (cell) ___________________________ **OK to leave message?** ___

Telephone: (home/work) ____________________ **OK to leave message?** ___

Email: ___________________________

Date of Birth: _________________ **Age:** ____ **Gender:** ______

Occupation: _________________________ **Education:** ___________________

Name: ____________________________________

Address: ____

Telephone: (cell) ___________________________ **OK to leave message?** ___

Telephone: (home/work) ____________________ **OK to leave message?** ___

Email: ________________________________

Date of Birth: _________________ **Age:** ____ **Gender:** ______

Occupation: _________________________ **Education:** ______________________

Name and number of person I can contact in case of emergency:

____

Relationship Status: Single____ Partnered____ Married____ Divorced____ Widowed____

If Married or Partnered, how long? ______________________________

Please list the current members of your household:

Name	Age	Relationship to You

How did you learn about my services? ____________________________

If either of you has had previous counseling or therapy, briefly describe this experience (when, with whom, and why you sought help).

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Briefly describe your reasons for seeking counseling:

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List any medical problems or physical symptoms: _________________________

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____

Please list any medications that you are currently taking.

Name of medication	Dose	Taken for:	Prescribed by:

Have either of you thought about hurting or killing yourself within the past 6 months?
No__ Yes___

Have either of you ever attempted suicide? No___ Yes___ If Yes, when? ________

What do you believe are your greatest sources of strength as individuals and as a couple? What are some key things that are working for you (you feel good about) as individuals and as a couple?

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Thank you for completing this form.