

Barbara A. Segal, LPC, NCC, CHT

Mindful Pathways Counseling

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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).

Briefly describe your reasons for seeking counseling:

List any medical problems or physical symptoms: _____

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?**

Thank you for completing this form.