COUPLES HISTORY

Please answer the following questions to the best of your knowledge. Each partner should fill out this form individually. Please note: information you provide here is protected as confidential information.

Name:			
Address:			
Home phone:		May I leave a message?	
Cell phone:		May I leave a message?	
email:		May I email you?	
Referred by (if a	applicable):		
Date of birth:			
Marital status:	Never married	Domestic partnership	Married
	Separated	Divorced	Widowed
Please list any	children/ages:		
Have you ever p	participated in psy	chotherapy before?	_ If yes, when?
Have you ever l	had psychiatric se	rvices before? If	yes, when?
Have you ever I	been hospitalized	for a mental health reason	? Dates?
Have you ever I	had thoughts of su	uicide or attempted suicide	? If yes, when?

Have you ever had any serious illnesses? Seizures? Head injuries? If so, please list:
Do you have any current specific health concerns? Chronic pain? If so, please list:
Do you take any medications (prescription/psychiatric) at this time? If so, please list medications and doctor prescribing:
How would you rate your current physical health on a scale of 1-10? Do you suffer from sleep problems? Please describe:
Do you have any problems with eating or appetite? Please describe:
How much do you exercise per week?
Are you currently experiencing overwhelming depression or grief? If yes, for how long?
Are you currently experiencing anxiety, panic attacks, or phobias? If yes, for how long?
Have you ever struggled with substance abuse issues? If yes, when?
Have you ever struggled with issues related to sexual orientation, gender identity, or gender dysphoria?

What significant life changes or stressful events have you experienced recently?					
Family mental health history: Please list a following issues and their relationship to y	ou (maternal aur	nt, paternal grandmother, etc).			
	Please circle	Family member			
Depression	yes/no				
Anxiety	yes/no				
Bipolar Disorder	yes/no				
Schizophrenia	yes/no				
Eating Disorder	yes/no				
Substance abuse	yes/no				
Domestic violence	yes/no				
Self-injurious behavior	yes/no				
Suicide attempt	yes/no				
Are you currently employed? Do you enjoy your work?					
Is there anything stressful about your wor	k?				
With which cultural or ethnic group(s), if a	ny, do you identif	y?			
Describe any issues/challenges you are e issues:					

Do you affiliate with any spiritual/religious group?
Please share any thoughts or information regarding your spiritual/religious beliefs that you feel it is important that I understand:
How long have you and your partner been together/married?
Has there ever been any history of violence in your relationship?
Describe your current living situation (composition of household, children/stepchildren how many, ages/genders)
What do you consider to be the strengths in your relationship?
What do you consider to be areas for continued growth in your relationship?
What brings you to couples counseling at this time? Particular events? Please be as specific as possible.

What would you like to accomplish in your time in couples therapy?					
**Please note that I do not see partners alone for couples therapy sessions. agree to come in together?	Do you				