

Initial Couple Information

Client #1

Date: _____ Ref'd By _____

First Name _____ Last: _____

Hm Phone _____ Cell _____ Wk _____

OK to leave messages? Hm Cell Wk Email _____

Address _____ City/Zip _____

Birth Date _____ M F Counseling interest: Individual Couple Family

Reason(s) for seeking counseling _____

Presenting Problem

- | | | |
|----------------------------------------|------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Work & Education |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Separation/Divorce | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Life Transition |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Parenting | <input type="checkbox"/> Finances/Health |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Abuse/Neglect | <input type="checkbox"/> Other _____ |

Health Practitioner: (name, phone, type) _____

Current problems, treatments? _____

Previous counseling/psychiatric care: (when, with whom, helpful?) _____

Relationship: Solo Dating Committed relationship Married* Separated Divorced Widowed

How many years? _____ *how long were you friends or dating before marriage? _____

Children (names, ages, in your care?) _____

Your relationship to parents/siblings? _____

Spiritual faith/interest? _____

Spiritual practice (meditation, prayer, etc.)? _____

Work: Employed (location) _____ Student Homemaker Retired Seeking Work

SELF-DESCRIPTION: Please check each item which describes your current feelings:

- | | | | | |
|------------------------------------|-------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Sad | <input type="checkbox"/> Distrustful | <input type="checkbox"/> Abused | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Energetic | <input type="checkbox"/> Irritable | <input type="checkbox"/> Worried | <input type="checkbox"/> Lonely | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Depressed | <input type="checkbox"/> Resentful | <input type="checkbox"/> Angry | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Inadequate | <input type="checkbox"/> Grieving | <input type="checkbox"/> Fearful | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Hopeful | <input type="checkbox"/> Jealous | <input type="checkbox"/> Numb | <input type="checkbox"/> Poor sex drive | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Isolated | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Fatigued | <input type="checkbox"/> Guilty | <input type="checkbox"/> Under/overeating | <input type="checkbox"/> Shame |

Initial Couple Information

Client #2

Date: _____ Ref'd By _____

First Name _____ Last: _____

Hm Phone _____ Cell _____ Wk _____

OK to leave messages? Hm Cell Wk Email _____

Address _____ City/Zip _____

Birth Date _____ M F Counseling interest: Individual Couple Family

Reason(s) for seeking counseling _____

Presenting Problem

- | | | |
|----------------------------------------|------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Work & Education |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Separation/Divorce | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Life Transition |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Parenting | <input type="checkbox"/> Finances/Health |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Abuse/Neglect | <input type="checkbox"/> Other _____ |

Health Practitioner: (name, phone, type) _____

Current problems, treatments? _____

Previous counseling/psychiatric care: (when, with whom, helpful?) _____

Relationship: Solo Dating Committed relationship Married* Separated Divorced Widowed

How many years? _____ *how long were you friends or dating before marriage? _____

Children (names, ages, in your care?) _____

Your relationship to parents/siblings? _____

Spiritual faith/interest? _____

Spiritual practice (meditation, prayer, etc.)? _____

Work: Employed (location) _____ Student Homemaker Retired Seeking Work

SELF-DESCRIPTION: Please check each item which describes your current feelings:

- | | | | | |
|------------------------------------|-------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Sad | <input type="checkbox"/> Distrustful | <input type="checkbox"/> Abused | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Energetic | <input type="checkbox"/> Irritable | <input type="checkbox"/> Worried | <input type="checkbox"/> Lonely | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Depressed | <input type="checkbox"/> Resentful | <input type="checkbox"/> Angry | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Inadequate | <input type="checkbox"/> Grieving | <input type="checkbox"/> Fearful | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Hopeful | <input type="checkbox"/> Jealous | <input type="checkbox"/> Numb | <input type="checkbox"/> Poor sex drive | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Isolated | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Fatigued | <input type="checkbox"/> Guilty | <input type="checkbox"/> Under/overeating | <input type="checkbox"/> Shame |