

New Client Form (Couples)

Date _____

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

General Client Information

Name: _____ Gender: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Soc. Security # _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Place of Birth: _____ Ethnic/Cultural Background: _____ Religion: _____

Education: _____ Occupation: _____ Employer: _____

Marital Status: single ____ never married ____ engaged ____ living together without marriage ____ separated ____ how long? ____

divorced ____ how long? ____ widow/er ____ how long? ____, Married ____ Spouse name _____ Age ____

Spouses Occupation _____ How long married to this spouse? ____ Are you happy in this marriage? ____

Previously married? ____ Total number prior marriages for you ____ For your spouse ____

Total number of children for you ____ For your spouse ____

Current Issues

Please provide a brief description of why you are seeking couples counseling/therapy at this time:

- Has anything happened that may have brought on/intensified the problems you are experiencing as a couple?

Yes No

If yes, please explain: _____

- How many days, weeks, months, or years have you been experiencing problems in your relationship? _____

- How much is/are the problem(s) affecting you? Mildly Moderately Severely

- In what areas does your relationship problems impact your life? (Check all that apply)
 - Lifestyle (the way you live your life)
 - Activities (things you normally do or would like to do)
 - Eating
 - Sleeping
 - Mood
 - Have you ever attempted suicide? Yes No If yes, when? _____)
 - Have you been thinking about suicide? Yes No
 - Have you ever experienced or witnessed a traumatic event? Yes No
 If yes, please explain _____
-

Have you had a significant loss or had someone close to you die? Yes No

Adult Problems Checklist

Instructions: Please check all that apply to you.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Performing unusual rituals or habits | <input type="checkbox"/> Grief/bereavement |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Heart racing | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Health problems |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Chest pain or heaviness | <input type="checkbox"/> Excessive behaviors (Examples: spending, gambling) | <input type="checkbox"/> Impact of your problems on others |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Chills / hot flashes | <input type="checkbox"/> Delusions / hallucinations (Thinking / believing or Seeing / hearing unusual things) | <input type="checkbox"/> Losing track of time |
| <input type="checkbox"/> Lack of interest/enjoyment in life | <input type="checkbox"/> Tingling/numbness | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Problems with memory |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Pain | <input type="checkbox"/> Self injurious behaviors | <input type="checkbox"/> Unpleasant thoughts that won't go away |
| <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Shyness | <input type="checkbox"/> Bothered by recurring thoughts |
| <input type="checkbox"/> Feeling guilty or shameful | <input type="checkbox"/> Fear of going "crazy" | <input type="checkbox"/> Social skills | <input type="checkbox"/> Job/career problems or indecision |
| <input type="checkbox"/> Sleep changes | <input type="checkbox"/> Nausea | <input type="checkbox"/> Social support (family/friends) | <input type="checkbox"/> Destruction of property |
| <input type="checkbox"/> (more/less) | <input type="checkbox"/> Fears or phobias | <input type="checkbox"/> Stealing | <input type="checkbox"/> Self-criticism |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Obsessions/compulsions | <input type="checkbox"/> Strange, weird, or peculiar behavior | <input type="checkbox"/> Family problems |
| <input type="checkbox"/> Bad dreams/nightmares | <input type="checkbox"/> Thoughts racing | <input type="checkbox"/> Confusion/can't think clearly | <input type="checkbox"/> Marital/relationship problems |
| <input type="checkbox"/> Feeling Ignored or Abandoned | <input type="checkbox"/> Disorganization | <input type="checkbox"/> Feeling "not real" | <input type="checkbox"/> Parent/child problems |
| <input type="checkbox"/> Appetite changes | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Feeling detached from yourself | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> (more/less) | <input type="checkbox"/> Can't hold onto an idea | <input type="checkbox"/> Feeling "hyper" | <input type="checkbox"/> Use of drugs |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anger/frustration | | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Thoughts of hurting self | <input type="checkbox"/> Suspiciousness or mistrustfulness | | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Problems trusting others | | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Isolating from others/social withdrawal | <input type="checkbox"/> Easily irritated/annoyed | | <input type="checkbox"/> Partner abuse |
| <input type="checkbox"/> Feelings of sadness/loss | <input type="checkbox"/> Aggressiveness | | <input type="checkbox"/> Trouble with the law |
| <input type="checkbox"/> Weight problems | <input type="checkbox"/> Perfectionist behavior | | |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Lying | | |
| | <input type="checkbox"/> Making/keeping friends | | |
| | <input type="checkbox"/> Arguing with others | | |

Please list the current prescription and over-the-counter medications you are currently taking:

Current Life Experiences

- I live with (list all members of household):

Name	Age	Relationship	Problem(s)
------	-----	--------------	------------

- Problems or changes in my family or other important interpersonal relationships (include name of person and relationship):

- Problems or changes in occupational, educational, social, or recreational functioning:

- My sources of satisfaction:

- My sources of stress:

- My leisure activities:

- What else do you want me to know: