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COUPLES INFORMATION

1) Name___________________________________ **Date of Birth**___________________

2) Name___________________________________ **Date of Birth**___________________

Address____
____

Home Phone___________________________ **Single Married Partner Divorced (circle one)**

1) Work Phone__________________________ **Cell Phone**__________________________

Occupation __________________________ **Employer**___________________________

2) Work Phone__________________________ **Cell Phone**__________________________

Occupation __________________________ **Employer**___________________________

Referred by ____

Have you been in therapy before? ______________ **If so, please list names of therapists or counseling professionals that have seen you, as well as the dates of services, as well as what was or was not helpful in your previous therapy experience.** ____
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____

My primary concern for treatment at this time is______________________________________
____
____

When did you first notice that you were experiencing problems, and what brings you to therapy now:

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____

Please list any medications that either of you are currently taking and for how long

____
____

What are your goals for treatment at this time?
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Describe any family, occupational or social stressors that may be contributing to your current problems or level of functioning

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Is there any other information that you would like to share? ____________________________

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