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**COUPLES INFORMATION FORM** Today's Date ________________

IDENTIFICATION

Name: _________________________________ Date of Birth: ____________ Age: _____

Contact Number: _______________________________ email: _________________________

Partner Name: ___________________________ Date of Birth: ____________ Age: _____

Contact Number: _______________________________ email: _________________________

Home address: ________________________________________________________________

Any restrictions on messages or other types of contact: __________________________________

______________________________________________________________________________

Marital Status: _________________________ Number of years together: __________

Previous Long term relationships: (status and length):

You: __________________________________________________________________________

______________________________________________________________________________

Partner: _______________________________________________________________________

______________________________________________________________________________

INSURANCE

Insurance provider: ____________________________ Policy # ______________________

Insured's Name: _______________________________ Group # ______________________

Relationship to Insured: _________________________ Co-pay amt: ________________

EMPLOYMENT

Current Employer _____________________________ Phone: _______________ Ok to call? Y?N

Address: ______________________________________________________________________

Partner Employer _____________________________ Phone: _______________ Ok to call? Y?N

Address: ______________________________________________________________________

Referral: How were you referred to me? ___________________________________________

Main concerns for your visit: ___________________________________________________

______________________________________________________________________________

______________________________________________________________________________

When did the problems begin? What were the precipitating events to the problem?

______________________________________________________________________________

______________________________________________________________________________

What have you tried to work out these problems: _______________________________________

______________________________________________________________________________

How enjoyable is your sexual relationship for you: 1 2 3 4 5 6 7 8 9 10

For your partner: : 1 2 3 4 5 6 7 8 9 10

What is the average frequency of your relations: _______ times per _______

Are you satisfied with that frequency? □Yes □No Is your partner satisfied? □ Yes □ No

Has the frequency changed recently: ___________________________________________________

CHILDREN

| Name | Male/Female | Age | Concerns? | Quality of relationship | Living/Deceased (date of death) |
|---|---|---|---|---|---|
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FAMILY

| | Name | Male/Female | Age | Quality of relationship | Living/Deceased (date of death) |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Sibling | | | | | |
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PARTNER FAMILY

| | Name | Male/Female | Age | Quality of relationship | Living/Deceased (date of death) |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Sibling | | | | | |
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Are either you or your partner having or had you had previous psychotherapy? □No □Yes
Previous therapist's name______________________________ Last visit: ________________
Concerning: ___________________________________________________________________

Are you or your partner currently taking prescribed medication? □Yes □No
If Yes, please list: ____________________________________________________________________
______________________________________________________________________________________

PRESENTING PROBLEMS

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc): _____________________________________________________

Partner: How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc): _____________________________________________________

2. Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other ________________________________________________________________

Partner: Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other ________________________________________________________________

3. Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

Partner: Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

4. Do you regularly use alcohol? □ No □ Yes How often/amount: ________________
Partner: Do you regularly use alcohol? □ No □ Yes How often/amount: ________________

5. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never
Partner: Suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

6. In the last year, have you or your partner experienced any significant life changes or stressors:
______________________________________________________________________________
______________________________________________________________________________

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? □ Yes □ No Partner: □ Yes □ No
If yes, what is your faith? ____________________________________________________
If no, do you consider yourself to be spiritual? □ No □ Yes Partner: □Yes □No

❑ I have been given the information on confidentiality and HIPAA.

______________________________________________ ____________________
Signature Date

______________________________________________ ____________________
Partner Signature Date