COUPLE ADMISSION FORM

Date:_____

GENERAL INFORMATION

Names:_____

Address:_____

Street City State Zip

Home Phone/s:_____ **Okay to leave message? __Yes __No**

Work Phone/s:_____ **Okay to leave message? __Yes __No**

Cell Phone/s:_____ **Okay to leave message? __Yes __No**

Email/s:_____

Date of Births:_____

How did you find out about my services?_____

Emergency Contact:_____

Name

_____

Home Phone Work Phone

_____

Relationship to you

Please describe your ethnicity (ies):_____

Please describe any spiritual/religious beliefs:_____

_____

Purpose for counseling:

What would you like to accomplish through counseling:

What are your strengths as a couple?

What are your weaknesses as a couple?

RELATIONSHIP INFORMATION

Current relationship status: ___Married/Partnered ___Separated ___Dating

___Single ___Divorced ___Engaged

___Cohabitating ___Widowed ___Other

Your sexual orientation: ___Gay/Lesbian ___Heterosexual ___Bisexual

___Other _____

Information on people living in the household:

Name	Age	Gender	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Significant others outside of the household:

Name	Age	Gender	Relationship to you
_____	_____	_____	_____

_____ _____ _____ _____

Past and present marriage/s (years together, names and statement about the nature of the relationship/s (i.e., friendly, distant, physically/emotionally/mentally abusive, loving, hostile):

_____

_____

_____

_____

Do you share custody of any children? ___ Yes ___No

If yes, child/ren name/s:_____

What percent of the time do they live with you?_____

Who else do they live with:_____

Please answer the below questions for all participating in therapy. Indicate the family member's name next to the appropriate response.

MEDICAL/TREATMENT HISTORY

Previous counseling/therapy? ___Yes ___No

If yes, please indicate dates, whether inpatient/outpatient, problem for which you were treated and name of treating professional:

_____

_____

Have either of you ever been hospitalized for psychiatric reasons: ___Yes ___No

If yes, please indicate when/why:

_____

_____

Please list any allergies/drug sensitivities:_____

Any current medical conditions?_____

_____

Prescription Drugs:

Type Amount Frequency Date last used

_____

_____

_____

_____

Past/present drug/alcohol use/abuse (AA, NA, treatments):

_____

_____

_____

_____

Coffee #_____ cups daily

Cigarettes #_____ per day

Alcohol # drinks/daily_____ or weekly_____ Date last drank:_____

Street drugs:
Type:_____ Frequency:_____

ADDITIONAL INFORMATION

Any history of Physical Abuse: ___Yes ___No
If yes, please explain:_____

_____

Any history of Incest or Sexual Abuse as a Child or Adolescent? ___Yes ___No
If yes, please explain:_____

_____

Any history of Sexual Assault or Rape as an Adult? ___Yes ___No
If yes, please explain:_____

_____

Any history of Spouse/Partner Abuse? ___Yes ___No
If yes, please explain:_____

_____

Any history of Criminal Activity? ___Yes ___No
If yes, please explain:_____

_____

Any history of major loss and/or death? ___Yes ___No
If yes, please explain:_____

_____

Is anyone in the family considering/threatening suicide? ___Yes ___No
If yes, please explain:_____

_____

Is there a history of suicide attempts? ___Yes ___No
If yes, please explain:_____

_____

Please indicate how the following symptoms/problems/complaints are effecting you:

0-No effect 1–Little effect 2-Some affect 3–Much effect 4-Significant effect

___ Eating habits/Appetite (eating more or less)
___ Weight change: If so, what amount____
___ Binge/purge
___ Sleep: Trouble falling asleep
___ Sleep: Trouble staying asleep
___ Sleep: Trouble waking up

Average # of hours of sleep per day _____
# of Naps daily ____

___Decreased energy/fatigue
___Sexual functioning
___Loss of interest in activities
___Tearfulness
___Hopelessness/Helplessness

___Decreased attention span
___Inattentive/Distractible
___Memory: Long term
___Memory: Short term
___Difficulty planning ahead
___Spending sprees
___Rapid heartbeat
___Phobia
___Sweating
___Trouble breathing
___Flashbacks of traumatic event
___Nightmares
___Racing thoughts
___Impulse control; difficulty controlling physical behavior/hyperactive
___Mood changes
___Anxious/Nervous
___Worry/Fear
___Hearing Voices
___Seeing things that are not there
___Stealing
___Anger outburst
___Panic attacks – Frequency_____

Please rate how the following symptoms/problems/complaints are impacting areas of functioning:

0-No effect 1–Mild 2-Moderate 3–Severe

___Marriage/Relationship
___Work/School
___Family
___Friendships
___Financial situation
___Physical health
___Social interests
___Leisure activities
___Clubs/Group memberships
___Legal
___Housing
___Attending to daily living activities (i.e., shower, grooming, self care, etc.)

___Spirituality
___Other:_____