Counseling and Wellness Center of South Florida

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Couple Information

Welcome to the practice. To speed up the initial process if you both would please fill out this form as completely as possible, we will be able to get started quickly. All information you both provide will be kept confidential within the guidelines expresses in the Client Handbook. Thank you.

Please Print

Spouse/Partner #1 Name:________________________ Date:__________ FILE #______
Address:____
(City)___________________________________ State:_____________ Zip:___________
Age:___ Date of Birth:___/___/___ Gender_________________________

	OK to Contact		OK to send/leave message	
Email Address:_________________	Y	N	Y	N
Home Telephone:_______________	Y	N	Y	N
Work Telephone:_______________	Y	N	Y	N
Cell Phone:_____________________	Y	N	Y	N

Place of Birth:____________________How long have you lived in Florida?__________
Military Service: Branch:______________ From_____________To________________
Education:____
Current Occupation:____
Employed By:____
Address;____
(City):_______________________________________State:____________Zip:_________
Describe your primary reason for coming to counseling:___________________________
____
____
____

Please Sign__________________________________

Spouse/Partner #2 Name:____________________________
Address:____
(City)____________________________________ State:_____________ Zip:___________
Age:___ Date of Birth:___/___/___ Gender________________________

	OK to Contact		OK to send/leave message	
Email Address:_________________	Y	N	Y	N
Home Telephone:_______________	Y	N	Y	N
Work Telephone:_______________	Y	N	Y	N
Cell Phone:____________________	Y	N	Y	N

Place of Birth:___________________How long have you lived in Florida?__________
Military Service: Branch:______________ From_____________To________________
Education:____
Current Occupation:____
Employed By:____
Address;____
(City):_____________________________________State:____________Zip:_________

Describe your primary reason for coming to counseling:___________________________
____
____
____

Please Sign___________________________________

Whom may I thank for referring you?
Name:_________________________Address:_______________________________
City:__________________________State:______Zip:__________Phone:____________
We give our permission to send a letter of acknowledgment to our referral source:
____
(Signatures)

Family Information

Current Marital Status:

Engaged: _ Married: _ Divorced:_ Separated:_ Co-Habitating:_

List all household members:

Name	Age	Relationship	Occupation/(School/Grade)
1.______________	________	_______________	_______________________
2.______________	________	_______________	_______________________
3.______________	________	_______________	_______________________
4.______________	________	_______________	_______________________
5.______________	________	_______________	_______________________
6.______________	________	_______________	_______________________

Spouse #1 List all of <u>your</u> marriages or significant relationships including this one.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1.____________	_____________	_______________	_________________
2.____________	_____________	_______________	_________________
3.____________	_____________	_______________	_________________

Spouse #2 List all of <u>your</u> marriages or significant relationships including this one.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1.____________	_____________	_______________	_________________
2.____________	_____________	_______________	_________________
3.____________	_____________	_______________	_________________

Spouse/Partner #1 Medical and Psychotherapy History

Any Surgeries? Yes □ No □

Procedure	Date	Comments/Outcome

Any current medical diagnosis or diseases? Yes □ No □

Diagnosis	Date	Comments/Status

Any current treatments or therapies for these conditions? Yes □ No □

____

Family Impact of Diagnosis:

____

Any previous psychotherapy? Yes □ No □

Date Started	Date Completed	Purpose of Therapy	Therapist

How helpful was it? Much improved □ Somewhat improved □ Improved □
Worse □ Somewhat worse □ Much worse □ No change □

Any hospitalizations? Yes □ No □

Date	Hospital	Reason

Current Medications:

Medication	Dose	Prescribing Physician

May I contact physician(s) to co-ordinate treatment? Yes □ No □
Signature:____

Spouse/Partner #2 Medical and Psychotherapy History

Any Surgeries? Yes □ No □

Procedure	Date	Comments/Outcome
____________________	__________	____________________________________
____________________	__________	____________________________________

Any current medical diagnosis or diseases? Yes □ No □

Diagnosis	Date	Comments/Status
____________________	__________	____________________________________
____________________	__________	____________________________________

Any current treatments or therapies for these conditions? Yes □ No □

____

Family Impact of Diagnosis:

____

Any previous psychotherapy? Yes □ No □

Date Started	Date Completed	Purpose of Therapy	Therapist
_______	_________	_______________________	______________

How helpful was it? Much improved □ Somewhat improved □ Improved □
Worse □ Somewhat worse □ Much worse □ No change □

Any hospitalizations? Yes □ No □

Date	Hospital	Reason
_______________	_____________________	_____________________________
_______________	_____________________	_____________________________

Current Medications:

Medication	Dose	Prescribing Physician
____________________	__________	______________________________
____________________	__________	______________________________
____________________	__________	______________________________

May I contact physician(s) to co-ordinate treatment? Yes □ No □

Signature: ____

Spouse/Partner #1 Clinical Information

Name: ______________________ Signature: ___________________________

Please check all items that you have experienced in the last 6 months:

Physical Symptoms
- □ Headaches
- □ Fainting Spells/ Dizziness
- □ No appetite/Overeating
- □ Stomach/ Bowel disturbances
- □ Palpitations
- □ Tremors – shaking
- □ Poor sleep
- □ Nightmares/ Night Tremors
- □ Unusual bodily sensations
- □ Sexual Problems
- □ Tired/No Energy

Emotional Symptoms
- □ Anxious
- □ Depressed
- □ Self-Esteem Issues
- □ Fears/Worries
- □ Inferiority feelings
- □ Panic Attacks
- □ Anger Issues
- □ Feeling Tense/Stressed
- □ Shy
- □ Poor Decision Making
- □ Lack Ambition or Interests
- □ Unable to relax

Social/Family Issues
- □ Marital/Partner problems
- □ Parent/Child problems
- □ Unemployed/Work Issues
- □ Financial Problems
- □ Court/Legal problems
- □ Problems making/keeping friends

Addictions
- □ Drinking problem
- □ Drug Abuse
- □ Gambling
- □ Sexual Addiction
- □ Food Addiction
- □ Excessive Shopping

Mental Health
- □ Previous Suicide Attempts
- □ Suicidal Ideas
- □ Visual Hallucinations
- □ Hearing Voices
- □ Disturbing thoughts or fears
- □ Manic

□ Other____

Please describe in detail those items checked above and for how long you have been experiencing each:

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Spouse/Partner #2 Clinical Information

Name: ______________________ Signature: ___________________________________

Please check all items that you have experienced in the last 6 months:

Physical Symptoms
- □ Headaches
- □ Fainting Spells/ Dizziness
- □ No appetite/Overeating
- □ Stomach/ Bowel disturbances
- □ Palpitations
- □ Tremors – shaking
- □ Poor sleep
- □ Nightmares/ Night Tremors
- □ Unusual bodily sensations
- □ Sexual Problems
- □ Tired/No Energy

Emotional Symptoms
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- □ Disturbing thoughts or fears
- □ Manic

□ Other____

Please describe in detail those items checked above and for how long you have been experiencing each:

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