PARTNER #1

Please take your time in filling out this history form – the more open and thorough you are, the better I can help you! Thank you.

Name:	Today's Date: / /

Please describe any individual mental health struggles you experience:

_____

_____

_____

Please describe any previous mental health care/counseling or alternative therapies you have received including when/where/issues sought treatment for:

_____

_____

_____

_____

Do you have a history of suicidal thoughts? *(please circle)* YES NO

If YES, have you had any suicide attempts? *(please circle)* YES NO

Have you ever been hospitalized for mental health? *(please circle)* YES NO

If YES, when, and what for?_____

Have you ever engaged in self-harming behaviors (ex. Cutting, burning self, etc)? *(please circle)* YES NO

Please list any medications you are currently taking (including over the counter):

_____

_____

_____

Previous mental health medications: _____

_____

_____

Please list any substances you are currently using including how much and how often (alcohol, caffeine, nicotine, marijuana, cocaine/crack, heroin/opiates, etc.) :

_____

_____

Have you ever struggled with substance use? *(please circle)* YES NO

Are you involved in any legal matters at this time? If yes, please describe:

_____

_____

_____

What is your current stress level overall? (please circle)

(low) 1 2 3 4 5 6 7 8 9 10(high)

Are you sexually active? *(please circle)* YES NO

If YES, do you use contraceptives to prevent pregnancy and/or STIs? *(please circle)* YES NO

If YES, what methods do you use? _____
_____
How **satisfied** are you with your sex life currently? *(please circle)*
NOT AT ALL SOMEWHAT SATISFIED VERY SATISFIED
Please describe any sexual problems you would like help with:_____
_____
_____
_____
_____
Has anyone ***ever*** been sexual with you (intercourse or not) without your consent? *(please circle)* YES NO
If YES, When? _____
Have you ever been abused (physically or mentally) in an intimate relationship? *(please circle)* YES NO
Family Information: Please list your parents, siblings, and yourself according to age:

1	5	9
2	6	10
3	7	11
4	8	12

Please circle any deceased family members.
Are your parents married? *(please circle)* YES NO
Please list any children you have (name and gender) and their ages:
_____
_____
_____

Please describe any developmental concerns from your childhood (divorce, trauma, deaths in family, frequent moving, learning disabilities, school issues, discipline, etc). _____
_____
_____
_____
_____
Please describe your emotional support system – who do you talk to? _____
_____
_____
_____
Rank order the top 3 concerns you have in your relationship with your partner:
_1_____
_2_____
_3_____
_____
What have you already tried to cope with the difficulties? :
_____
_____

_____
_____

What are your biggest strengths as a couple?

_____
_____
_____
_____

How was conflict handled in your family growing up?

_____
_____
_____
_____

_What are the top 3 things you appreciate about your partner or relationship?
__1_____
__2_____
__3_____
_____

Is there anything else you would like me to know?

_____
_____
_____
_____

PARTNER #2

Please take your time in filling out this history form – the more open and thorough you are, the better I can help you! Thank you.

Name:	Today's Date: / /

Please describe any individual mental health struggles you experience:

_____

_____

_____

Please describe any previous mental health care/counseling or alternative therapies you have received including when/where/issues sought treatment for:

_____

_____

_____

_____

Do you have a history of suicidal thoughts? *(please circle)* YES NO

If YES, have you had any suicide attempts? *(please circle)* YES NO

Have you ever been hospitalized for mental health? *(please circle)* YES NO

If YES, when, and what for?_____

Have you ever engaged in self-harming behaviors (ex. Cutting, burning self, etc)? *(please circle)* YES NO

Please list any medications you are currently taking (including over the counter):

_____

_____

_____

Previous mental health medications: _____

_____

_____

Please list any substances you are currently using including how much and how often (alcohol, caffeine, nicotine, marijuana, cocaine/crack, heroin/opiates, etc.) :

_____

_____

Have you ever struggled with substance use? *(please circle)* YES NO

Are you involved in any legal matters at this time? If yes, please describe:

_____

_____

_____

What is your current stress level overall? (please circle)

(low) 1 2 3 4 5 6 7 8 9 10(high)

Are you sexually active? *(please circle)* YES NO

If YES, do you use contraceptives to prevent pregnancy and/or STIs? *(please circle)* YES NO

If YES, what methods do you use? _____
_____
How **satisfied** are you with your sex life currently? *(please circle)*
NOT AT ALL SOMEWHAT SATISFIED VERY SATISFIED
Please describe any sexual problems you would like help with:_____
_____
_____
_____
_____
Has anyone ***ever*** been sexual with you (intercourse or not) without your consent? *(please circle)* YES NO
If YES, When? _____
Have you ever been abused (physically or mentally) in an intimate relationship? *(please circle)* YES NO
Family Information: Please list your parents, siblings, and yourself according to age:

1	5	9
2	6	10
3	7	11
4	8	12

Please circle any deceased family members.
Are your parents married? *(please circle)* YES NO
Please list any children you have (name and gender) and their ages:
_____
_____
_____

Please describe any developmental concerns from your childhood (divorce, trauma, deaths in family, frequent moving, learning disabilities, school issues, discipline, etc). _____
_____
_____
_____
_____
Please describe your emotional support system – who do you talk to? _____
_____
_____
_____
Rank order the top 3 concerns you have in your relationship with your partner:
_1_____
_2_____
_3_____
_____
What have you already tried to cope with the difficulties? :
_____
_____

_____
_____

What are your biggest strengths as a couple?

_____
_____
_____
_____

How was conflict handled in your family growing up?

_____
_____
_____
_____

_What are the top 3 things you appreciate about your partner or relationship?
__1_____
__2_____
__3_____
_____

Is there anything else you would like me to know?

_____
_____
_____
_____

****** COUPLES – Please choose a primary patient to fill this out ******

Patient's Name (Last, First, MI)_____
Name prefer to be called: _____DOB_____ _____ Gender_____
Patient's Marital Status:____Single ____Married____Other
Patient's Employment Status: ___Employed___Full-Time___Student___Part-Time Student, ___Other
Referred By: _____
Patient's Email address:_____
Second Email address (optional):
_____

If you'd like to be able to e-mail me securely, and make appointments online, please CREATE a login name and password (10 character MAX)
Login Name: _____ ***Password:***_____

Address:_____
City: _____State:_____Zip Code:_____
Home Phone Number_____
Work Phone Number _____Work Extension:_____
Cell Phone Number:_____
Cell Phone Carrier:_____
Second Cell Phone Number
(optional):_____
Emergency Contact (name and number):
_____

What kind of appointment reminders would you like?
___Email (requires email address)
___Text Message (requires cell phone number and carrier)
___Phone call (requires home phone number)
___None (no reminder will be sent)

If insurance will be used, fill in this section:
Primary Insurance Company: _____
Insurance I.D. Number: _____
Insurance Group Number: _____
Effective Date (e.g. 1/1/03): _____
Patient's relationship to Insured:___Self ___Spouse___Child___Other
Insured Name (**Last, First MI**): _____
Insured's Street Address: _____
Insured's City: _____Insured's State:____Insured's Zip Code: _____
Insured's Phone Number:_____
(******IMPORTANT****)** Insured's Date of Birth (e.g. 3/4/1956): _____
Insured's Employer: _____

If you have secondary insurance, please let me know. *Thank you for your time!*