COME 2 CHANGE COUNSELING, LLC

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Patient Information: Couples Counseling

Date: _____

Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

E-mail address:_____(NEVER shared or sold; for newsletter or updates only)

Age:_____ Birth Date:_____ Relationship status: E M P S W D

Religion_____ Race_____ Nationality_____

Occupation:_____ Employer:_____

Spouse:_____ Occupation:_____Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Previous marriages? _____If so how long married_____ Date of last divorce: _____

Number of years in current relationship _____

Name of Emergency Contact:_____Phone:_____

How did you hear about me?_____

Family Medical Doctor (first and last name): _____

Month and year of last physical:_____

HISTORY OF PRESENTING COUPLE CHALLENGES:

Current couple challenges: _____

_____

Have you ever had the same or similar challenges? ____ Yes ____ No If yes, when and describe:

_____

Are you able to effectively perform academic, social or occupational tasks? ____ Yes ____ No If no, when and describe:

_____

PAST HISTORY

Have you previously or do you currently have: (Place a check mark by conditions that apply to you)

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__ Suicide Attempts/Thoughts
__ Homicidal Thoughts
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, describe: _____

What medications or drugs are you taking? (List name and dosage)

_____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

_____

Have you been in individual or couples counseling before? No__ Yes__ If yes, year and therapist name:

Have you been hospitalized for substance abuse or inpatient psychiatric treatment? No__ Yes__ if yes, where and year:_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?_____ If so, how much per day:_____
Do you exercise?_____
Do you sleep well at night? _____ If no, why not? _____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

Have you had concern with any of the below currently or past with your partner?

Alcoholic consumption_____
Illicit Drug Use_____
Infidelity_____
Physical Abuse_____
Emotional Abuse_____

FAMILY HISTORY:

Parents:

Father: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Mother: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Do you have any family members who suffer from the same marital issues as you do? _____ If so, please list:

_____ _____

_____ _____

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

__Family violence: verbal __Family violence: physical

1. What is your major concern?

   _____

   _____

   _____

   Other concerns: _____

   _____

   _____

2. If this is a recurring problem, when was the first time you experienced this problem?

   _____

   _____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? _____

   _____

3. How frequently do you experience this problem in your relationship? Constant _____ Intermittent ____

   What contributes to the creation and/or worsening of your problem(s)?

   _____

   _____

   _____

4. Challenges you would like to discuss?

   _____

   _____

5. What have you tried to do that has not helped? _____

_____

6. Do you still want to be in relationship, or are you here to discuss separation and/or divorce/termination? YES/ NO /UNSURE.

If no, what relationship concerns do you wish to explore and resolve in therapy? _____

_____

7. Remarks, things not mentioned so far that I should know:

_____

_____

CURRENT LEVEL OF STRESS*

NO SYMPTOMS/STRESS — EXTREME SYMPTOMS/STRESS

*Please place an "X" **on the line above** to indicate level of stress resulting from problem.

Patient's Signature _____ Date _____

Therapist's Signature_____ Date_____

RELATIONSHIP SATISFACTION SCALE

Name: **Date**:

Directions: On a scale of one to 10, please put a number beside each area of your relationship to indicate how you feel.

1=very unsatisfied___2___3___4____5 =Okay, not great ___6_____7_____8_____9___10=very satisfied

A) Companionship (talking, sharing your day, being friends): ____

B) Sexual intimacy (frequency, closeness, mutual satisfaction) ____

C) Respect (courtesy, fair fighting, thoughtfulness of your spouse) ___

D) Shared interests (time with children, hobbies)___

E) Community/church/social involvement___

F) Finances: communicating, compromising:___

G) Any other areas that are positive? If so, name and rate:

1. ____

2. ____

3. ____

H) Any other areas that you want to work on? If so, name and rate:

1. ___

2. ___

3. ___

COMMENTS: MORE YOU NEED TO SAY?

Attachment