

Name _____

Presbyterian Counseling Center

Date of Birth _____

Couple Counseling Initial Information Form

Date _____

<Each Partner completes their own form.>

Current Situation

What concern brings you to therapy? How long has this been a problem? What have you been doing about it? What do you hope to get out of therapy now?

Yourself

What strengths and assets do you have?

- | | |
|---|---|
| <input type="checkbox"/> Able to express feelings appropriately | <input type="checkbox"/> Good physical health |
| <input type="checkbox"/> Accuracy of perception | <input type="checkbox"/> Insight into problems |
| <input type="checkbox"/> Awareness of assets & limitations | <input type="checkbox"/> Leisure interests |
| <input type="checkbox"/> Capable of independent living | <input type="checkbox"/> Motivated for treatment |
| <input type="checkbox"/> Capacity for logical thinking | <input type="checkbox"/> Belief/Religion/Spiritual Practice |
| <input type="checkbox"/> Community support | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Employment stability | <input type="checkbox"/> Support of family & friends |
| <input type="checkbox"/> Financially stable | <input type="checkbox"/> Supportive groups |
| <input type="checkbox"/> Flexibility of adaptation | <input type="checkbox"/> Work skills |
| <input type="checkbox"/> Frustration tolerance | <input type="checkbox"/> Other _____ |

Your Mental Health History

Have you ever been to a counselor before? No Yes How many? ____ How many sessions? ____
Any psychiatric hospitalizations? No Yes How many times? ____

Your Health History

In general, your health is Excellent Good Fair Poor

When was your last physical examination? _____

Do you use tobacco? No Yes ____ Packs/day Other _____

The nutritional value and balance of your diet is: Excellent Good Fair Poor

How often do you exercise? Daily 2-4 times per week Occasionally Never

Has your weight changed in recent months? No Yes. How many pounds? _____ ↑ ↓

How much sleep do you get? _____ hours of what quality? Good Fair Poor

Any trouble with sexual functioning? No Yes _____

Any allergies: Seasonal Food Medicine _____

Names of medications you take	How much?	How often?	Do you take it consistently?
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_____			<input type="checkbox"/> Yes <input type="checkbox"/> No
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No

Name _____

Your Alcohol and Drug Use

Have you ever had concerns about your use of alcohol, medicines or drugs? Yes No

Has anyone else ever expressed concern about your use of alcohol, medicine or drugs? Yes No

Have you or anyone else had concerns about your use of sex, food or gambling? Yes No

Check any that you have had because of alcohol, medicine, drugs, sex, food or gambling.

- Financial problems
- Relationship problems
- Work problems
- Increased tolerance
- Physical problems
- Emotional problems
- Blackouts
- Withdrawal symptoms
- Cravings

Your Education

Completed: ___ Grade GED High School Some college/VoTech College More

Describe your school experience: _____

Your Employment

Full time Part time Student Volunteer Homemaker

Unemployed since _____ Disabled since _____ Retired since _____

How long at current job? _____ Yrs Mo Type of work: _____

How long at previous job? _____ Yrs Mo Type of work: _____

Any problems at work? No Yes _____

Were you in the military? No Yes. Combat duty? Yes No. Which service? _____

Current Family Relationships

Your children and their ages: _____

Who lives with you?	Name	Age	Relationship

Any concerns about them? No Yes _____

Has any partner been abusive to you? No Yes _____

Name _____

Your Family History

Your Father: Living, age _____. Died at age _____. How old were you at his death? _____

Your Mother: Living, age _____. Died at age _____. How old were you at her death? _____

Their marriage: Very happy Happy Ok Unhappy Very unhappy

Were your parents divorced? No Yes How old were you? _____

How often were you spanked as a child? Never A few times Often Whipped Beaten

How many brothers? _____ How many sisters? _____ Where are you in birth order? _____

How were your relationships with your siblings? Loving Squabbles Fights Destructive

Any members of your family ever had a problem with any of these things? Who was it?

Depression _____ Panic or Anxiety _____

Drinking too much _____ Mood swings _____

Getting violent _____ Sexual abuse / rape _____

Were you adopted? No Yes _____

Your relationship with your partner

If married, did you receive Pre-Marital Counseling? No Yes How many sessions? _____

How helpful was it? Very Helpful Helpful Fair Waste of time Bad

Sexual satisfaction: Very satisfied Satisfied So-so Unsatisfied Not sexual now

Previous marriages? No Yes _____

What three things would you like your partner to change?

1. _____
2. _____
3. _____

What three things would your partner like you to change?

1. _____
2. _____
3. _____

What three things would you like to change, just for yourself?

1. _____
2. _____
3. _____

Describe the following in three words and one thing they are not:

Yourself: _____ Not _____

Partner: _____ Not _____

Father: _____ Not _____

Mother: _____ Not _____

Siblings: _____ Not _____

_____ Not _____

_____ Not _____

God: _____ Not _____

Name _____

Other comments

Anything else that would be helpful for the counselor to know you better?

Thank you for your time, honesty and courage in answering these questions.