Name _____

Counseling Center New Smyrna Beach 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?

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

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?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ 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 _____
	_____	_____	_____	Not _____

Name _____

Other comments

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

_____

_____

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