



**Client Information - Couple**

(All information provided here is confidential.)

Today's Date: \_\_\_\_\_

Name:	Date of birth__ / __ / __	
SSN:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Address:	City:	Zip:
Home phone:	Cell phone:	
Employer:	Work phone:	

married engaged living together

Name:	Date of birth__ / __ / __	
SSN:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Address:	City:	Zip:
Home phone:	Cell phone:	
Employer:	Work phone:	

How were you referred to Sarah Appleton? \_\_\_\_\_

Have you previously received mental or behavioral health services? Yes No

If yes, when? \_\_\_\_\_ what issues were treated? \_\_\_\_\_

Are you currently on any medication? Yes No If yes, please list \_\_\_\_\_

What significant life changes or stressful events have you experienced recently?

\_\_\_\_\_

In the section below identify if there is a family history of any of the following.

If yes, please indicate the family member's relationship to the child in the space provided (father, grandmother, uncle, etc.).

	<u>Please Circle</u>	<u>List Family Member</u>
Alcohol/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you consider yourselves to be spiritual or religious? Yes No

If yes, describe your faith or belief \_\_\_\_\_

What would you like to accomplish from your time in therapy? \_\_\_\_\_