Demographics

Name: ____ Date: __________________

Address: _________________________________ City: ________________State: _____ Zip:________

County: ________________ Phone: (H) ______________ (C) ______________ (W) _____________

Email: ________________________________ Method of contact: Phone or Email (circle one)

It is customary GCS practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address here:

____

Couple Information: *Please list those who will be present for counseling*

Name: ____ Age: _________________________

Religious Affiliation: ______________________________

Employer: ____________________ Occupation: ____________________________________

Marital Status: (circle one) Single Married (how long _______)

Divorced (how long _______) Widowed

Name: ___________________________________ Age: ________ DOB: ____________

Religious Affiliation: ________________________________

Employer: ___________________________Occupation: ____________________________________

Marital Status: (circle one) Single Married (how long _______) Divorced (how long ___) Widowed

Children: *If children are stepsiblings or partial siblings please indicate next to their name*

Name	Age

Mental Health:

- Has anyone in the immediate family currently or historically been suicidal? (if so who and when?)
  ____
- Has anyone in the immediate family ever been hospitalized for mental health related issues?
  ____
- Is anyone in the immediate family currently receiving counseling services with another professional? If so who and for how long?
  ____

1) What is the primary concern or issue that led you to decide to seek therapy?

____
____

2) Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? If yes for either, who, how often and what substances are used?
____

3) Has anyone in the family ever struck, physically restrained, used violence against or injured any other person within the family? (If yes, please explain)
____

____

4) Have either of you considered separating or divorce as a result of the current marital problems? If so, when?
____

5) List some strengths in your relationship.

Partner 1: ____

Partner 2: ____

6) List some weaknesses in your relationship.

Partner 1: ____

Partner 2: ____

7) How would you know that your time in therapy has been successful? What looks different in your relationship?

____

____

Partner 1: Circle any problem that pertains to you at the present:			Partner 2: Circle any problem that pertains to you at the present:		
Anger	Education	Sexual Problems	Anger	Education	Sexual Problems
Work	Drug Use	Loneliness	Work	Drug Use	Loneliness
Relationship	Fatigue	Ambition	Relationship	Fatigue	Ambition
Stomach Problems	Finances	My Appearance	Stomach Problems	Finances	My Appearance
Suicidal Thoughts	Fears about the Future	Friends	Suicidal Thoughts	Fears about the Future	Friends

Concentration	Nightmares	Temper
My thoughts	Parenthood	Health Problems
Age	Nervousness	Ability to Relax
Making Decisions	Stress	Self-esteem
Sexual Orientation	Sexual Desire	Sexual Satisfaction
Physical Abuse	Anxiety	Separation
Energy	Feeling of Inferiority	Appetite
Sexual Abuse	Children	Career Choices
Weight	Shyness	Legal Matters
Self-Control	Memory	Sleep
Under / Over-eating	Alcohol Use	Unhappiness
Depression	Headaches	Fears
Other: ___________		

Circle everything that has happened to you in the past three years:

Death of a spouse/partner
Relationship Problems
Changes in relationship status
Death of another family member
Family Problems (Children, in-laws)
Loss of Job
Major illness or injury–yourself
Financial Problems
Move to another city or state
Major illness or injury–family member
Legal Problems
Other: ____________________

Concentration	Nightmares	Temper
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Financial Problems
Move to another city or state
Major illness or injury–family member
Legal Problems
Other: ____________________

Referred by: ____

Emergency contact information:

Name ____

Relationship: ________________________ Phone: ____________

Client Signature: ________________________ Date: __________

Client Signature: Date: