

TODAY'S DATE: _____

YOUR INFORMATION

Name: _____
Age: _____ Address: _____ State: _____ Zip: _____
City: _____
Home Phone: _____ Business Phone: _____
Mobile #: _____ Email Address: _____
Profession: _____
Number Years Married to Current Spouse: _____
Children's Names and Ages: _____
Previous Marriage(s) & Length of Marriage(s): _____

SPOUSE'S INFORMATION

Spouse's Name: _____
Spouse's Address: _____
City: _____ State: _____ Zip: _____
Spouse's Age: _____
Spouse's Previous Marriage(s) & Number Years Previously Married: _____
Spouse's Health: _____
Spouse's Profession: _____

YOUR FAMILY OF ORIGIN

Mother's Name: _____ Mother's Profession: _____
Father's Name: _____ Father's Profession: _____
Mother's Age: _____ Mother's Location: _____
Father's Age: _____ Father's Location: _____
Mother's Health: _____
Father's Health: _____
Are your parents currently married? Yes No If not, when did they divorce? _____

Write 3 positive adjectives to describe your Mother:

- (1) _____
- (2) _____
- (3) _____

Write 3 negative adjectives to describe your mother:

- (1) _____
- (2) _____
- (3) _____

Write 3 positive adjectives to describe your Father:

- (1) _____
- (2) _____
- (3) _____

Write 3 negative adjectives to describe your Father:

- (1) _____
- (2) _____
- (3) _____

Please provide a list of therapists you are currently seeing (if any). For each, include their role, and whether I have permission to contact him or her if need be.

CURRENT PROBLEM/ISSUES - Please provide description of current problems and issues to be addressed:

HEALTH CHECKLIST - Check all that apply to each family member and yourself

	You	Spouse	Children	Briefly Explain
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Workaholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spending/Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sex Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

ADDITIONAL INFORMATION

I would like each of you attending the session to send a one-page summary to me giving background information and your desired outcomes for the session. Please limit your response to a single page.