ATLAS COUNSELING

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Phone: 314-991-0100 x728 or x740 | Fax: 314-991-0100 | www.atlascounselingstl.com

NEW COUPLE INFORMATION FORM

Relationship Background

Please circle the relationship status that best describes the relationship.

Married Engaged Committed, unmarried Separated

If these descriptions do not fit your relationship, please explain in your own words.

____

Please circle the relationship dynamics that best describe the relationship. Circle all that apply.

Polyamorous Open Monogamous Asexual

If these descriptions do not fit your relationship, please explain in your own words.

____

How long have you and your partner been in a relationship? ________________________________

Please describe any previous separations, break-ups, or divorces within this relationship.

____

____

Do you and your partner live together? □ No □ Yes

Do you and your partner have children? □ No □ Yes

If so, please complete the following:

Name	Age	Gender	Relationship	Living with You?

Partner #1 Information

Name (Last, First, MI)	Date of Birth	Age
Address	City/State/Zip	Phone Number
Employer	Position	Education Completed

Self-Identity

Please let us know how you identify your gender, and your preferred pronouns.

Please let us know how you identify your sexuality.

Please let us know how you identify your race or ethnicity.

Please let us know if you identify strongly with a specific culture.

Please let us know if you have any spiritual or religious beliefs that are important to you.

History of Care

Please list any medications you are currently taking (name, dosage, prescriber, reason for medication).

Please list any mental health care you are currently receiving (name of practitioner, dates of care).

Please list any psychiatric medications you have taken previously (name, dosage, prescriber, reason for medication).

Please list any mental health care you have received previously, including inpatient care or hospitalization for psychiatric reasons (name of practitioner, dates of care).

Please let us know of any psychiatric conditions or learning disabilities with which you have been diagnosed.

____

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Family Mental Health History

In the section below, please identify if there is a family history of any of the following conditions. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	No	Yes	Relationship
Alcohol/Substance Use			
Anxiety			
Bipolar/Manic-Depression			
Depression			
Domestic Violence			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide/Suicide Attempts			

General Health and Welfare

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please let us know of any specific health concerns you are currently experiencing, including any developmental or acquired disabilities.

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____

How would you rate your current sexual relationship? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please let us know of any specific sexual concerns you are experiencing.

____

____

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? ____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ______________________________

Please indicate if you have a history of using the substances below. If yes, please indicate the amount used and frequency of use:

	Currently Using	Previously Used	Never Used
Alcohol			
Marijuana			
Cocaine/crack			
Heroine/Narcotics			
Amphetamines			
Depressants			
PCP			
LSD			
Inhalants			
Tobacco/Nicotine			
Caffeine			
Other			

Additional Information

Overall, how would you rate your relationship? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

What significant life changes or stressful events has your relationship experienced recently?

____

____

____

What do you enjoy about your relationship? Is there anything stressful about your relationship?

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What do you consider to be some of the strengths of your relationship?

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What do you consider to be some of the challenges of your relationship?

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What would you like to accomplish out of your time in therapy?

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Client Signature Date

Partner #2 Information

Name (Last, First, MI)	Date of Birth	Age
Address	City/State/Zip	Phone Number
Employer	Position	Education Completed

Self-Identity

Please let us know how you identify your gender, and your preferred pronouns.

Please let us know how you identify your sexuality.

Please let us know how you identify your race or ethnicity.

Please let us know if you identify strongly with a specific culture.

Please let us know if you have any spiritual or religious beliefs that are important to you.

History of Care

Please list any medications you are currently taking (name, dosage, prescriber, reason for medication).

Please list any mental health care you are currently receiving (name of practitioner, dates of care).

Please list any psychiatric medications you have taken previously (name, dosage, prescriber, reason for medication).

Please list any mental health care you have received previously, including inpatient care or hospitalization for psychiatric reasons (name of practitioner, dates of care).

Please let us know of any psychiatric conditions or learning disabilities with which you have been diagnosed.

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Family Mental Health History

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Bipolar/Manic-Depression			
Depression			
Domestic Violence			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide/Suicide Attempts			

General Health and Welfare

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please let us know of any specific health concerns you are currently experiencing, including any developmental or acquired disabilities.

____

____

How would you rate your current sexual relationship? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please let us know of any specific sexual concerns you are experiencing.

____

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Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? ____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ____________________

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Client Signature Date