**Stephanie L. Ezust, Ph.D.**

**CLIENT INFORMATION FORM FOR COUPLES – PART I**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_ /\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Highest Level of Education So far: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone #: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_ /\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Highest Level of Education So far: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone #: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other phone #’s? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU PLANNING TO USE INSURANCE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YES, WHOSE NAME WILL BE NOTED AS THE “IDENTIFIED PATIENT”? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I let them know you came? (Your signature indicates your consent; without further discussion and consent, I would let the referral person know you came, nothing more.)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature)

**CLIENT INFORMATION FORM FOR COUPLES – PART I , continued**

OTHER PEOPLE LIVING IN YOUR HOME:

Name Age Relationship to you Work Phone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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IF YOU HAVE CHILDREN, SIBLINGS, OR SIGNIFICANT OTHERS IN YOUR FAMILY WHO DO NOT LIVE WITH YOU, PLEASE LIST THEM BELOW:

Name Age Relationship to you Place of Residence

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CLIENT INFORMATION FOR COUPLES – PART II**

(each person participating in therapy should fill out Part II)

Have you worked with a therapist in the past? If yes, please list the name(s) of therapist(s) seen and dates of therapy.

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Please list name(s) of medication(s) you are taking along with the names and contact information for the prescribing physician(s). Also, please list any medications you have taken in the past for psychological problems.

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Briefly describe the problem(s) or issues which prompted you to seek counseling/psychotherapy at this time.

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Please describe what you hope will happen or be different as a result of your psychotherapy. What are your goals for this experience?

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**CLIENT INFORMATION FOR COUPLES – PART II, continued**

Please place a checkmark next to the each item below that is an area of concern for you. Place two checkmarks next to those items which are most important or of most concern.

\_\_\_\_\_ Anger \_\_\_\_\_ Religious/Spiritual Concerns

\_\_\_\_\_ Anxiety \_\_\_\_\_ Self-Esteem

\_\_\_\_\_ Depression/Unhappiness \_\_\_\_\_ Sexual Concerns

\_\_\_\_\_ Education/School Problems \_\_\_\_\_ Sexual Orientation/Identity

\_\_\_\_\_ Eating Problems/Disorders \_\_\_\_\_ Suicidal Thoughts

\_\_\_\_\_ Family Problems \_\_\_\_\_ Transition in Life

\_\_\_\_\_ Fearfulness \_\_\_\_\_ Trauma/Abuse Recovery

\_\_\_\_\_ Financial Problems \_\_\_\_\_ Trouble Making Decisions

\_\_\_\_\_ Grief \_\_\_\_\_ Use of Alcohol

\_\_\_\_\_ Health Concerns \_\_\_\_\_ Use of Drugs

\_\_\_\_\_ Marital/Relationship \_\_\_\_\_ Use of Alcohol or Drugs by a

\_\_\_\_\_ Problems with Intimate Significant Other

 Relationships \_\_\_\_\_ Vocational/Career Development

\_\_\_\_\_ Problems with Children \_\_\_\_\_ Work Related Conflicts or Concerns

\_\_\_\_\_ Other (please describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please add anything else you feel would be important for me to know or understand about you and your situation.