INTOWN
COUNSELING & WELLNESS

PARTNER INFORMATION FORM

Please fill out individually

Today's date: _____ **Date of birth:** _____

Your name: _____
Last First Middle Initial

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Work Phone:** _____

Home Phone: _____ **E-mail:** _____

Calls will be discreet, but please indicate any restrictions: _____

_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

_____

Have you ever talked with a psychiatrist, therapist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

_____

_____

Age: _____ Gender: _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Length of Current Relationship? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

_____

_____

_____

_____

Describe any problems any of your children are having: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

POOR EXCELLENT

Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

POOR EXCELLENT

Employment Satisfaction: 1 2 3 4 5 6 7

What do you think are your strengths?_____

_____

Below are a list of reasons couples typically come to therapy. Please circle any issues that you are interested in pursuing in treatment.

Blended Family Issues	Career Counseling	Commitment Issues	Communication Problems
Divorce/Separation/Break-Up	Grief/Loss	Infidelity	LGBT Issues
Men's/Women's Issues	Parenting Concerns	Physical Aggression	Pregnancy
Premarital Therapy	Polyamorous Relationship	Recent Diagnosis (mental)	Recent Diagnosis (physical)
Self-Esteem Issues	Sexual Aggression	Sexual Concerns	Stress Management
Substance Use/Abuse	Suicidal Ideation	Trust Issues	Verbal Aggression