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)? ______________________________

2921 Piedmont Rd, Suite C | Atlanta, GA 30305 | Office: (404) 478-9890 | Fax: (404) 963-0975 | www.intowncounseling.com

*****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__________________________

Intown Counseling & Wellness
2921 Piedmont Rd, Suite C | Atlanta, GA 30305 | Office: (404) 478-9890 | Fax: (404) 963-0975 | www.intowncounseling.com

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: ___________________
____
____

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

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?____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

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