DATE:_______________

Marriage and Family Institute of San Antonio

COUPLES
OR
FAMILY FORM

Partner 1 Name:____

Partner 2 Name:____

Address____________________________________City_____________________Zip________

Home Phone:__________________________ E-Mail:___________________________________

Partner 1: Insurance Primary Subscriber: Yes _______ No _________ NA ________

Date of Birth:__________________Age:_____________SS #:___________________

Occupation_______________________Company Name ________________________________

Work Address____Zip________

W. Phone________________ Cell/Pager:_______________ E-Mail:_______________________

Partner 2: Insurance Primary Subscriber: Yes ________ No ________NA ________

Date of Birth:__________________ Age:_________ SS #:____________________

Occupation_______________________ Company Name ________________________________

Work Address____Zip__________

W. Phone___________________ Cell/Pager:_______________ E-Mail:____________________

If applicable:

Children's Names	Age	Sex		Relationship	Living at home Yes	No

Are there any other persons living in your household? Yes______ No______ If yes, please give their name/s and their relationship to your family.

CURRENT LIVING SITUATION

Married_______ Separated_______ Widowed_______ Engaged_______ Co-Habitating________

How long have you been married?____________________

Have you been married before? If so, for how long were you married ?

Partner 1: Yes_____ No____ /______ Partner 2: Yes_____ No____/______

Are your parents living? If yes, please give their names.

1. Mother: Yes_____ No_____
   Father: Yes_____ No_____

2. Mother: Yes_____ No_____
   Father: Yes_____ No_____

BASIC HEALTH AND COUNSELING HISTORY

Partner 1: Good____ Fair____ Poor____ Date of last Physical Exam?____________________

Name of Physician?____ Phone_______________

Are you taking any prescription medication, over-the-counter medications, allergy medications, herbs, etc.? Yes_____ No_____ If yes,what? ____

____

____

Have you ever been hospitalized? Yes______ No_____ If so, for what?____________________

____

Do you drink alcohol? Yes____ No____If yes, amount? _________________________________

Do you use any illegal drugs? Yes____ No____ If yes, what?_____________________________

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes____ No____ If yes, what?____

____

Have you had counseling in the past? Yes____ No____. If so, From:__________To:__________

With whom?____________________________ For what?_________________________________

____

BASIC HEALTH AND COUNSELING HISTORY (cont.)

Partner 2: Good____ Fair____ Poor____ Date of last Physical Exam?____________________

Name of Physician?____ Phone_______________

Are you taking any prescription medication, over-the-counter medications, allergy medications, herbs, etc.? Yes_____ No_____ If yes,what? ____

____

____

Have you ever been hospitalized? Yes______ No_____ If so, for what?____________________

____

Do you drink alcohol? Yes____ No____If yes, amount? _________________________________

Do you use any illegal drugs? Yes____ No____ If yes, what?_____________________________

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes____ No____ If yes, what?____

Have you had counseling in the past? Yes____ No____. If so, From:__________To:__________

With whom?____________________________ For what?_______________________________

Children:

Have any of your children ever see a counselor before? Yes__No__Child;s name______________

If yes, From_____ To______ With whom?____

For what?____

Do any of your children have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes_____ No_______ If yes, what?__________________________________

Do any of your children have any current social, intellectual, or academic problems?

Yes_____No_______ If yes, what?____

Were there any significant prenatal or perinatal events during the pregnancy/birth of any of your children? Yes_____ No_______ If yes, what?____

What medications or substances do your children use, if any? Yes_____ No_______

If yes, what?____

Have any of your children been hospitalized? Yes_____ No_______

If yes, for what?____

What is the name of the children's physician? ____

REASON(S) FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling?

What would you like to see happen as a result of counseling?

The thing which concerns us the most right now is?

RATE YOUR CURRENT MENTAL STATUS:

Please circle the appropriate answer **G = Good** **F = Fair** **P = Poor**

	His	Hers	His	Hers	His	Hers
1. Memory/Short	G	G	F	F	P	P
2. Memory/Long	G	G	F	F	P	P
3. Insight/Judgement	G	G	F	F	P	P
4. Attention	G	G	F	F	P	P
5. Concentration	G	G	F	F	P	P
6. Affect/Mood	G	G	F	F	P	P
7. Eye Contact	G	G	F	F	P	P
8. Body Movement	G	G	F	F	P	P
9. Speech	G	G	F	F	P	P
10. Impulse Control	G	G	F	F	P	P

Comments: ____

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POLICY

A counseling session is normally 50 minutes. It is customary to pay your therapist after each session. If you are using your Insurance the deductible or copay will be collected by the Therapist. **Cash or Check only**. We **do not** accept credit cards. A 24-hour cancellation notice is appreciated; otherwise the usual fee may be charged.

The therapist will maintain strict confidentiality. However, I understand that suicidal threats, homicidal threats, or child abuse will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

I understand that I have the right to refuse treatment at any time.

Signature of Partner 1:___________________________________Date______________________

Signature of Partner 2:___________________________________Date______________________

Signature of Psychotherapist:____