



**COLORADO STATE UNIVERSITY  
CENTER FOR FAMILY AND COUPLE THERAPY  
CLIENT INFORMATION FORM**

Case Number: \_\_\_\_\_

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

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**Basic Information**

*The information you provide will help us serve you better and will be kept confidential within the limits described by your therapist. If you have any questions, please feel free to ask your therapist.*

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Phone number** (Please list two numbers where you can easily be reached):

Number: \_\_\_\_\_ Cell/Work/ Home (Circle one)

Okay to leave a message? Yes/No

Number: \_\_\_\_\_ Cell/Work/Home (Circle one)

Okay to leave a message? Yes/No

**Address:** \_\_\_\_\_ **City/State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Emergency Contact List:**

In case of an emergency please list the name, address, and phone number of **two** people who are **not** in therapy with you that we would be able to contact (this information is required):

**Contact 1:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Contact 2:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Have you had any previous therapy or counseling experience?**

- No
- Yes

If yes, was it individual, couple, family therapy? \_\_\_\_\_

When was the experience? \_\_\_\_\_

What type of counseling was it? Please describe. \_\_\_\_\_

**If applicable, please list your children below:**

<u>Child's Name</u>	<u>DOB</u>	<u>Gender</u>	<u>Relation to You (biological, step, foster )</u>	<u>Lives with you?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How many people live in your home, including yourself? \_\_\_\_\_

**Occupation** (check all that apply):

- Part-time Student; Name of school/university: \_\_\_\_\_
- Full-time Student; Name of school/university: \_\_\_\_\_
- Part-time Employed; Name of Employer: \_\_\_\_\_  
Job Title: \_\_\_\_\_
- Full-time Employed; Name of Employer: \_\_\_\_\_  
Job Title: \_\_\_\_\_
- Other (please list): \_\_\_\_\_
- Gross Annual Household Income \$ \_\_\_\_\_

**Ethnicity** (check all that apply):

- Caucasian (White, Anglo)
- African-American (Black)
- Hispanic-American
- Asian American
- Native American
- Pacific Islander
- Other – please specify: \_\_\_\_\_

**Religious/spiritual affiliation:**

- Catholic
- Christian/Protestant
- Jewish
- LDS
- Muslim
- Hindu
- Buddhist
- Other – please specify: \_\_\_\_\_
- No religious affiliation

**Highest Level of Education:**

- Less than a high school degree
- High school degree or GED
- Some college
- Technical or trade school
- Bachelor's degree
- Some graduate school
- Graduate school degree

**Gender**

- Male
- Female
- Transgender

**Relationship Status** (please check all that apply):

- Married: \_\_\_\_\_ years \_\_\_\_\_ months
- Separated: \_\_\_\_\_ years \_\_\_\_\_ months
- Divorced: \_\_\_\_\_ years \_\_\_\_\_ months
- Widowed: \_\_\_\_\_ years \_\_\_\_\_ months
- Living together: \_\_\_\_\_ years \_\_\_\_\_ months
- Engaged: \_\_\_\_\_ years \_\_\_\_\_ months
- Committed partnership: \_\_\_\_\_ years \_\_\_\_\_ months
- Single: \_\_\_\_\_ years \_\_\_\_\_ months
- Other (please specify): \_\_\_\_\_

If applicable, what is the name, age, and gender of your current spouse or partner?

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

## Medical History

**Primary Physician:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

When did you last see a physician? \_\_\_\_\_

Please list any health or medical problems within the last five years:

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**Please any medications you are currently taking, including psychiatric medications:**

Medication

Why Prescribed

_____	_____
_____	_____
_____	_____

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*Please answer the following questions to the best of your knowledge.*

Please list the type and amount of alcohol used currently:

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Additionally, please describe any past or current problems with alcohol abuse (including attempts to quit or cut down, past treatment, arrests, DUIs, etc.):

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Please list the type and amount of any (street) drugs used currently:

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Additionally, please describe any past or current problems with drug abuse (including attempts to quit or cut down, past treatment, arrests, DUIs, etc.):

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*Now we'd like to ask you about some other issues some people may have experienced in their past and current relationships. Please answer these questions as honestly as you can.*

Do you feel safe in your current relationship?                      Physically                      Emotionally  
Yes \_\_\_\_\_ No \_\_\_\_\_                      Yes \_\_\_\_\_ No \_\_\_\_\_

Do your arguments escalate out of control?                      Never                      Rarely                      Occasionally                      Very Often

Have you ever pushed, slapped, hit, kicked, punched, or otherwise hurt **your partner or spouse** in the past year?

- No
- Yes

Please use the following space if you'd like to provide more detail. \_\_\_\_\_

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Have you been pushed, slapped, hit, kicked, punched, or otherwise hurt by **a partner or spouse** in the past year?

- No
- Yes

Please use the following space if you'd like to provide more detail. \_\_\_\_\_

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**Please place a check (✓) in the box beside all of the following statements that apply to you:**

*My partner ... (or parent, sibling, etc.)*

- |                                                                           |                                                                         |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> tries to control who I spend my time with        | <input type="checkbox"/> verbally attacks my personality                |
| <input type="checkbox"/> does not believe me when I say where I've been   | <input type="checkbox"/> prevents me from leaving the house when I want |
| <input type="checkbox"/> is suspicious that I am unfaithful               | <input type="checkbox"/> ridicules me                                   |
| <input type="checkbox"/> keeps me from doing things I want to do          | <input type="checkbox"/> threatens me physically during arguments       |
| <input type="checkbox"/> keeps me from spending time at things I enjoy    | <input type="checkbox"/> threatens to hurt someone I care about         |
| <input type="checkbox"/> pressures me to have sex when I don't want to    | <input type="checkbox"/> damages things in our home                     |
| <input type="checkbox"/> talks me into doing things that make me feel bad | <input type="checkbox"/> humiliates me in front of others               |

**Please place a check (✓) in the box beside all of the following statements that apply to you:**

*I have ...*

- |                                                                                                |                                                                                                |
|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> tried to control who my partner spends time with                      | <input type="checkbox"/> tried to talk my partner into doing things that make him/her feel bad |
| <input type="checkbox"/> not believed my partner when he/she has told me where he/she has been | <input type="checkbox"/> verbally attack my partner's personality                              |
| <input type="checkbox"/> been suspicious that my partner has been unfaithful                   | <input type="checkbox"/> prevent my partner from leaving the house when he/she wants to        |
| <input type="checkbox"/> tried to keep my partner from doing things he/she has wanted to do    | <input type="checkbox"/> ridicule my partner                                                   |
| <input type="checkbox"/> kept my partner from spending time at things he/she enjoys            | <input type="checkbox"/> threaten my partner physically during arguments                       |
| <input type="checkbox"/> pressured my to have sex when he/she doesn't want to                  | <input type="checkbox"/> threaten to hurt someone my partner cares about                       |
|                                                                                                | <input type="checkbox"/> damage things in our home                                             |
|                                                                                                | <input type="checkbox"/> humiliate my partner in front of others                               |
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How did you hear about the Center for Family and Couple Therapy?

- Word of Mouth
- Referral from professional
- Brochure
- Internet
- Phone Book
- Advertisement

Briefly state the reasons you are seeking therapy at this time. That is, describe the main problem that brings you to our Center and what you hope to gain from therapy.

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### Client Medication Log

Client #1's Name \_\_\_\_\_

	<b>Name of Med</b>	<b>For what Diagnosis</b>	<b>Dosage</b>	<b>Frequency Taken</b>	<b>Approx. Date Started</b>	<b>Prescribing Person/Phone*</b>	<b>Pos or Neg Side Effects?</b>
<b>Med 1</b>							
<b>Med 2</b>							
<b>Med 3</b>							
<b>Med 4</b>							
<b>Med 5</b>							
<b>Med 6</b>							

\*We would like to ask for a release of information to speak with each client's prescribing health care professional to coordinate care.

Client #2's Name \_\_\_\_\_

	<b>Name of Med</b>	<b>For what Diagnosis</b>	<b>Dosage</b>	<b>Frequency Taken</b>	<b>Approx. date started</b>	<b>Prescribing person/phone*</b>	<b>Pos or Neg Side effects?</b>
<b>Med 1</b>							
<b>Med 2</b>							
<b>Med 3</b>							
<b>Med 4</b>							
<b>Med 5</b>							
<b>Med 6</b>							

\*We would like to ask for a release of information to speak with each client's prescribing health care professional to coordinate care.