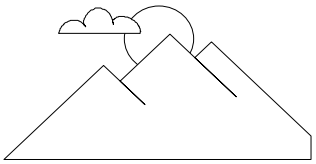

COLORADO STATE UNIVERSITY
CENTER FOR FAMILY AND COUPLE THERAPY
CLIENT INFORMATION FORM

Case Number: _____ Date: _____

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:

Child's Name	DOB	Gender	Relation to You (biological, step, foster)	Lives with you?

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:_____

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

Religious/spiritual affiliation:

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

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:

_____

_____

_____

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

Medication	Why Prescribed
_____	_____
_____	_____
_____	_____

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

Please list the type and amount of alcohol used currently:

_____

_____

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

_____

_____

_____

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

_____

_____

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

_____

_____

_____

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 Yes_____ No_____ Emotionally 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. _____

_____

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. _____

_____

Please place a check (√) in the box beside all of the following statements that apply to you:
My partner … (or parent, sibling, etc.)

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

- ☐ tried to control who my partner spends time with
- ☐ not believed my partner when he/she has told me where he/she has been
- ☐ been suspicious that my partner has been unfaithful
- ☐ tried to keep my partner from doing things he/she has wanted to do
- ☐ kept my partner from spending time at things he/she enjoys
- ☐ pressured my to have sex when he/she doesn't want to
- ☐ tried to talk my partner into doing things that make him/her feel bad
- ☐ verbally attack my partner's personality
- ☐ prevent my partner from leaving the house when he/she wants to
- ☐ ridicule my partner
- ☐ threaten my partner physically during arguments
- ☐ threaten to hurt someone my partner cares about
- ☐ damage things in our home
- ☐ humiliate my partner in front of others

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.

_____

_____

_____

_____

_____

Client Medication Log

Client #1's Name_____

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

*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_____

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

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