

Name:	DOB (Age)
Partner:	DOB (age)
Children? (Names & Ages)	Pets?
Relevant Past Relationships?	
Address	
Email	Referral Source
Mobile	Medicare No
Work Status	Health Insurance
Next of Kin	Emergency Contact
Completed Client Disclosure?	Completed Biography?

Biography

1) What brings you to my practice?

2) Have you had therapy before? If yes, when and how was it?

3) What are your couple therapy goals?

4) Rate your overall relationship satisfaction from 1 (lowest) of 100 (highest)

5) What are your relationship's strengths?

6) What are your relationship's weaknesses?

7) What factors are/ may have contributed to your relationship's problems?

a) -Past?

b) -Present / Ongoing?

c) -Future?

d) Other?

