Richard Brousell, MFT, MAC, LPCMH
COUPLE DATA FORM

PARTNER #1
NAME_____ D.O.B._____

HOME PHONE_____ CELL PHONE_____

ADDRESS _____ E-MAIL_____

(city)_____ (state)_____ (zip)_____

EMPLOYER_____ OCCUPATION_____

WORK PHONE_____
EMERGENCY CONTACT_____ PHONE_____

MARITAL HISTORY:
CURRENT STATUS: SINGLE_____ MARRIED_____
SEPARATED—DATE_____
DIVORCED—DATE_____
WIDOWED—DATE_____
PAST MARRIAGE(S) DATES_____ DATES_____

OTHER FAMILY MEMBERS IN THE HOME
NAME AGE RELATION

_____

_____

_____

_____

EDUCATIONAL HISTORY

HIGHEST LEVEL COMPLETED _____

LAST SCHOOL ATTENDED_____

MEDICAL STATUS:

ACUTE CONDITIONS_____
CHRONIC CONDITIONS_____
MEDICATIONS TAKEN:

PRESCRIBED_____
BY WHOM_____
PHONE_____
NON-PRESCIRBED (OVER THE COUNTER MEDS OR HERBAL PRODUCTS)_____
OTHER THERAPIES: CURRENT_____
PAST_____

TOBACCO USE: YES____ NO____; FREQUENCY AND AMOUNT_____
DRUG/ALCOHOL USE_____
LEGAL PROBLEMS_____

PRIMARY GOALS OF THERAPY:_____
_____
_____
_____
_____

HOW WERE YOU REFERRED TO THIS PRACTICE:

Word of mouth__
internet__ [Psychology Today__], [My website__] [other__]
family doctor or other professional__
other__

INSURANCE INFORMATION: Company_____
Member ID_____ Group#_____ Telephone #_____

_____ _____
PATIENT'S SIGNATURE DATE

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COUPLE DATA FORM

PARTNER #2
NAME_____ D.O.B._____

ADDRESS (if different from Partner #1)_____

(city)_____ (state)_____ (zip)_____

HOME PHONE_____ CELL PHONE_____

EMPLOYER_____ OCCUPATION_____

WORK PHONE_____ E-MAIL_____

EMERGENCY CONTACT_____ PHONE_____

MARITAL HISTORY:
CURRENT STATUS: SINGLE_____ MARRIED_____
SEPARATED—DATE_____
DIVORCED—DATE_____
WIDOWED—DATE_____
PAST MARRIAGE(S) DATES_____ DATES_____

OTHER FAMILY MEMBERS IN THE HOME
NAME AGE RELATION

_____

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_____

EDUCATIONAL HISTORY

HIGHEST LEVEL COMPLETED _____

LAST SCHOOL ATTENDED_____

MEDICAL STATUS:
ACUTE CONDITIONS_____

CHRONIC CONDITIONS_____
MEDICATIONS TAKEN:
PRESCRIBED_____
BY WHOM_____
PHONE_____
NON-PRESCIRBED (OVER THE COUNTER MEDS OR HERBAL PRODUCTS)_____
OTHER THERAPIES: CURRENT_____
PAST_____

TOBACCO USE: YES____ NO____; FREQUENCY AND AMOUNT_____
DRUG/ALCOHOL USE_____
LEGAL PROBLEMS_____

PRIMARY GOALS OF
THERAPY:_____
_____
_____
_____
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HOW WERE YOU REFERRED TO THIS PRACTICE:

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family doctor or other professional__
other__

INSURANCE INFORMATION: Company_____
Member ID_____ Group#_____ Telephone #_____

_____ _____
PATIENT'S SIGNATURE DATE