STEPHANIE D. MILLER, MA
LMFT, LPC, LCDC

Couples Client Information

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Professional Services Agreement and Informed Consent Form and the HIPAA Notice of Privacy Practices contained therein. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

PARTNER #1 INFORMATION

NAME: _____ DATE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____City, Zip Code_____

TELEPHONE: Home: _____ Office: _____

Cell: _____ Fax: _____

E-MAIL: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: If same as above, write, "Same as above"

Address: _____

Phone: _____ Text: Yes or No *Circle One*

Email: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

EMPLOYER: _____

OCCUPATION (former, if retired): _____

PERSON AND PHONE NO. TO CALL IN EMERGENCY:

_____

REFERRAL SOURCE: _____

What would you say is the primary problem in your marriage? (Be as specific as you can: When did it start, how does it affect you.):

_____

_____

What is your goal for therapy?

_____

_____

How long have you been in a committed relationship? _____

Have you been married before? _____

How long did each prior marriage last? 1st _____ 2nd_____ 3rd_____
PAST & PRESENT RELATIONSHIPS (Provide a statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

_____

_____

Do you have children from those prior relationships/marriages? ❑ Yes ❑ No

Child's Name	Age	From Relationship or Marriage #	Live with You

IF PARENTS DIVORCED: Your age at the time: _____ Describe how it affected you at the time: _____

Are you currently seeing another mental health professional? ❑ Yes ❑ No

If yes, what is the focus of therapy?

_____

MEDICAL DOCTOR/S (name /phone): _____

Specify all MEDICATION you are presently taking and for what. PRINT clearly:

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):_____

_____

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, browsing, etc.): Facebook: _____ YouTube: _____ Gaming: _____ Browsing: _____ Other: _____

What gives you most joy or pleasure in your life? _____

_____

What are your main worries and fears? _____

_____

What are your most important hopes or dreams? _____

_____

Additional comments: _____

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PARTNER #2 INFORMATION

NAME: _____ DATE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____

TELEPHONE: Home: _____ Office: _____

Cell: _____ Fax: _____

E-MAIL: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: If same as above, write, "Same as above"

Address: _____

Phone: _____ Text: Yes or No *Circle One*

Email: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

EMPLOYER: _____

OCCUPATION (former, if retired): _____

PERSON AND PHONE NO. TO CALL IN EMERGENCY:

_____

REFERRAL SOURCE: _____

OCCUPATION (former, if retired): _____

What would you say is the primary problem in your marriage? (Be as specific as you can: When did it start, how does it affect you.):

_____

_____

What is your goal for therapy?

_____

_____

How long have you been married? _____ Have you been married before? _____

How long did each prior marriage last? 1st _____ 2nd_____ 3rd_____

PAST & PRESENT MARRIAGE/S (Provide a statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

_____

_____

Do you have children from those prior marriages? ❑ Yes ❑ No

Child's Name	Age	From Relationship or Marriage #	Live with You

IF PARENTS DIVORCED: Your age at the time: _____ Describe how it affected you at the time: _____

Are you currently seeing another mental health professional? ❑ Yes ❑ No

If yes, what is the focus of therapy?

_____

MEDICAL DOCTOR/S (name /phone): _____

Specify all MEDICATION you are presently taking and for what. PRINT clearly:

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):_____

_____

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, browsing, etc.): Facebook: _____ YouTube: _____ Gaming: _____ Browsing: _____ Other: _____

What gives you most joy or pleasure in your life? _____

_____

What are your main worries and fears? _____

_____

What are your most important hopes or dreams? _____

_____

Additional comments: _____

Couple Client Information

This page can be completed by either partner. Use additional paper as needed for every child.

CHILDREN INFORMATION

Do the partners have children together from the present union? ❑ Yes ❑ No

Child #1 Name: _____ DOB: _____

Does the child live in the family home? ❑ Yes ❑ No

Is there a problem with this child that will be a focus of therapy? ❑ Yes ❑ No

If yes, identifying the presenting problem: _____

_____

_____

_____

Child #2 Name: _____ DOB: _____

Does the child live in the family home? ❑ Yes ❑ No

Is there a problem with this child that will be a focus of therapy? ❑ Yes ❑ No

If yes, identifying the presenting problem: _____

_____

_____

_____

Child #3 Name: _____ DOB: _____

Does the child live in the family home? ❑ Yes ❑ No

Is there a problem with this child that will be a focus of therapy? ❑ Yes ❑ No

If yes, identifying the presenting problem: _____

_____

_____

_____

Child #4 Name: _____ DOB: _____

Does the child live in the family home? ❑ Yes ❑ No

Is there a problem with this child that will be a focus of therapy? ❑ Yes ❑ No

If yes, identifying the presenting problem: _____

_____

_____

_____