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**Living Perspective Counseling, Inc.**

3020 Broadmoor Lane, Suite 200

Flower Mound, TX 75022

[www.livingperspectivecounseling.com](http://www.livingperspectivecounseling.com)

Office: 972-539-7373

**Couple and/or Family Counseling Background Information Form**

Date:

**Significant Other/Parent**:

 First Middle Last

Date of Birth: Age: Gender: Race/ethnicity:

Preferred Pronouns (i.e. she/her; he/his; they/them):

**Significant Other/Parent**:

 First Middle Last

Date of Birth: Age: Gender: Race/ethnicity:

Preferred Pronouns (i.e. she/her; he/his; they/them):

**Step-parents** (if applicable):

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age**  | **Gender**  | **Length of Relationship** |
|  |  |  |  |
|  |  |  |  |

**Children (if Applicable):**

|  |  |  |
| --- | --- | --- |
| **Name** | **Age**  | **Gender**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Primary Address:

Number & Street City State Zip

Phone: (Cell) Can a message be left? [ ]  Yes [ ]  No

 (Home/work) Can a message be left? [ ] Yes [ ]  No

Email:

Have you previously been a client of our practice? [ ]  Yes [ ]  No

How did you learn about us? [ ] **Internet** [ ] **Other Professional** [ ] **School** [ ] **Friend** [ ] **Clergy**

[ ] **Other**:

Emergency Contact: (Name) (relation) (cell phone)

**PEOPLE CURRENTLY IN HOUSEHOLD**

 Name Relation to Client Age Gender Education Level Occupation

1.

2.

3.

4.

Continue on back if necessary.

Any children not living in household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gross Family Income (before taxes) $ Number of Dependents

## **What brings you here: Current Concerns**

Please describe the concerns, problems, or issues that have motivated you to seek professional services at this time. Indicate which are most important or need most immediate attention:

How long has the concern(s) been present? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any significant stressors (i.e. losses, births, deaths, moves, hospitalizations, etc) in the last several years? If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What attempts, if any, have been made to resolve the difficulties your family is currently experiencing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the symptoms that the family is currently experiencing. Please indicate to which family member you are referring:

|  |  |
| --- | --- |
| **Symptom/Concern**  | **Family Member(s) Experiencing this Concern:** |
| Feeling Overwhelmed  |  |
| Feeling Anxious  |  |
| Sleep Difficulties  |  |
| Appetite Changes (increase or decrease)  |  |
| Significant Changes in Weight (increase or decrease)  |  |
| Alcohol/Substance Use or other addictive behavior(s) |  |
| Poor self-care  |  |
| Problems at school and/or work |  |
| Feeling lonely  |  |
| Feeling sad or depressed  |  |
| Change in energy level (increase or decrease) |  |
| Feeling misunderstood  |  |
| Low self-esteem  |  |
| Physical pain, chronic pain, and/or significant health issues  |  |
| Obsessions and/or compulsions  |  |
| Feelings of hopelessness  |  |
| Perfectionism |  |
| Financial difficulties  |  |
| Excessive and/or inappropriate feelings of guilt  |  |
| Significant change in mood  |  |
| Spiritual Concerns  |  |
| Feelings of confusion |  |
| Feeling angry  |  |
| Feeling empty  |  |
| Victim of violence and/or crime  |  |
| Feelings of panic  |  |
| Traumatic Event (past or present, and what kind)  |  |
| Physical Abuse (past or present) |  |
| Sexual Abuse (past or present)  |  |
| Emotional Abuse (past or present)  |  |
| Grief  |  |
| Legal Issues  |  |
| Parent-child relationship concerns  |  |
| Sibling concerns  |  |
| Divorce/Separation  |  |

Other concern(s) not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are married or in an intimate relationship, which of the following terms best describe your relationship? (Check all that apply):

[ ] happy [ ]  balanced [ ] distant [ ]  intolerable [ ]  sexually satisfying [ ] tense [ ]  safe

[ ] disappointing [ ] predictable [ ] partner too dependent on you [ ] unstable [ ]  you’re too dependent on partner [ ] partner supportive of you [ ] affectionate [ ] you’re supportive of partner [ ]  secure [ ]  trusting

How long have you been in this relationship?

Is your partner be willing to participate in therapy with you?

Check any of the following that are sources of conflict or concern in your relationship:

[ ]  parenting style [ ]  parenting responsibilities [ ]  politics [ ]  religion [ ]  communication [ ]  lack of mutual caring [ ]  finances [ ]  sexuality [ ]  mutual interests [ ]  sharing resources [ ]  workloads [ ]  partner’s alcohol or drug use [ ]  sharing housework [ ]  your alcohol or drug use [ ]  your problems [ ]  partner's problems

## **Relationship Information**

Current Relationship Status:

[ ] Single (never married) [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Living with committed Partner [ ]  In committed relationship [ ]  Widowed [ ]  Other:

Name of Spouse/Significant Other:

Length of Marriage/Relationship:

Previous Marriages/Significant Relationships and Durations:

1. 3.
2. ­­­­­­­­­­ 4.

### Employment History

Are you currently employed? [ ]  Yes [ ]  No

If Yes, Where? How Long?

Is your significant other currently employed? [ ]  Yes [ ]  No

If Yes, Where? How Long?

## **Education History**

High School Diploma? [ ] Yes [ ]  No GED? [ ]  Yes [ ]  No

Highest grade completed:

Education/training beyond high school:

**Significant Other**:

High School Diploma? [ ] Yes [ ]  No GED? [ ]  Yes [ ]  No

Highest grade completed:

Education/training beyond high school:

### Medical History

Self-Assessment of Health: [ ]  Excellent [ ]  Good [ ]  Fair [ ]  Poor

Name of Primary Care Doctor and city located: (Phone):

Name of Psychiatrist (if applicable): (Phone)

Any Hospitalizations? [ ]  Yes [ ]  No If yes, please explain:

Sleep difficulties? [ ]  No [ ]  Yes

Any allergies? [ ]  No [ ]  Yes To:

Any current medications? [ ]  No [ ]  Yes

If so, please list names, dosages, and purposes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise or Physical Activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant Other**:

Self-Assessment of Health: [ ]  Excellent [ ]  Good [ ]  Fair [ ]  Poor

Name of Primary Care Doctor and city located: (Phone):

Name of Psychiatrist (if applicable): (Phone)

Any Hospitalizations? [ ]  Yes [ ]  No If yes, please explain:

Sleep difficulties? [ ]  No [ ]  Yes

Any allergies? [ ]  No [ ]  Yes To:

Any current medications? [ ]  No [ ]  Yes

If so, please list names, dosages, and purposes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise or Physical Activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Mental Health History

Have you ever received counseling/therapy before? [ ]  Yes [ ]  No

If yes, for what problem?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, Provider or agency name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric Hospitalizations? [ ]  Yes [ ]  No For what problem? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Suicidal Attempt [ ]  Yes [ ]  No Past Homicidal Ideation [ ]  Yes [ ]  No

Current Suicidal Ideation [ ]  Yes [ ]  No Current Homicidal Ideation [ ]  Yes [ ]  No

**Significant Other**:

Has your significant other ever received counseling/therapy before? [ ]  Yes [ ]  No

If yes, for what problem?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, Provider or agency name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric Hospitalizations? [ ]  Yes [ ]  No For what problem? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Suicidal Attempt [ ]  Yes [ ]  No Past Homicidal Ideation [ ]  Yes [ ]  No

Current Suicidal Ideation [ ]  Yes [ ]  No Current Homicidal Ideation [ ]  Yes [ ]  No

### Substance Abuse History

Check any that apply:

[ ] Alcohol/frequency [ ] Tobacco/frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Caffeine/frequency [ ] Marijuana/frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Additional Substance Abuse Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other addictive behavior(s) present? [ ]  Yes [ ]  No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Military Service History

Any military service? [ ]  Yes [ ]  No

If yes, please list dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, status of discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant Other**:

Any military service? [ ]  Yes [ ]  No

If yes, please list dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, status of discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of both Parents/Significant Others:

 Signature 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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