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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?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any other addictive behavior(s) present?  Yes  No

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

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### 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_