



Counseling and Wellness Center of South Florida

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- ___ Ellen Rondino, M.S.

Couple Information

Welcome to the practice. To speed up the initial process if you both would please fill out this form as completely as possible, we will be able to get started quickly. All information you both provide will be kept confidential within the guidelines expresses in the Client Handbook. Thank you.

Please Print

Spouse/Partner #1 Name: _____ **Date:** _____ **FILE #** _____
Address: _____
(City) _____ **State:** _____ **Zip:** _____
Age: ___ **Date of Birth:** ___/___/___ **Male_ Female_**

	OK to Contact		OK to send/leave message	
Email Address: _____	Y	N	Y	N
Home Telephone: _____	Y	N	Y	N
Work Telephone: _____	Y	N	Y	N
Cell Phone: _____	Y	N	Y	N

Place of Birth: _____ **How long have you lived in Florida?** _____
Military Service: Branch: _____ **From** _____ **To** _____
Education: _____
Current Occupation: _____
Employed By: _____
Address; _____
(City): _____ **State:** _____ **Zip:** _____

Describe your primary reason for coming to counseling: _____

Please Sign _____

Spouse/Partner #2 Name: _____

Address: _____

(City) _____ State: _____ Zip: _____

Age: ___ Date of Birth: ___/___/___ Male_ Female_

	OK to Contact		OK to send/leave message	
Email Address: _____	Y	N	Y	N
Home Telephone: _____	Y	N	Y	N
Work Telephone: _____	Y	N	Y	N
Cell Phone: _____	Y	N	Y	N

Place of Birth: _____ How long have you lived in Florida? _____

Military Service: Branch: _____ From _____ To _____

Education: _____

Current Occupation: _____

Employed By: _____

Address: _____

(City): _____ State: _____ Zip: _____

Describe your primary reason for coming to counseling: _____

Please Sign _____

Whom may I thank for referring you?

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

We give our permission to send a letter of acknowledgment to our referral source:

(Signatures)

Family Information

Current Marital Status:

Engaged: _ Married: _ Divorced: _ Separated: _ Co-Habiting: _

List all household members:

Name	Age	Relationship	Occupation/(School/Grade)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Spouse #1 List all of your marriages or significant relationships including this one.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Spouse #2 List all of your marriages or significant relationships including this one.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Spouse/Partner #1 Medical and Psychotherapy History

Any Surgeries? Yes No

Procedure	Date	Comments/Outcome
_____	_____	_____
_____	_____	_____

Any current medical diagnosis or diseases? Yes No

Diagnosis	Date	Comments/Status
_____	_____	_____
_____	_____	_____

Any current treatments or therapies for these conditions? Yes No

Family Impact of Diagnosis:

Any previous psychotherapy? Yes No

Date Started	Date Completed	Purpose of Therapy	Therapist
_____	_____	_____	_____

How helpful was it? Much improved Somewhat improved Improved
Worse Somewhat worse Much worse No change

Any hospitalizations? Yes No

Date	Hospital	Reason
_____	_____	_____
_____	_____	_____

Current Medications:

Medication	Dose	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

May I contact physician(s) to co-ordinate treatment? Yes No

Signature: _____

Spouse/Partner #2 Medical and Psychotherapy History

Any Surgeries? Yes No

Procedure	Date	Comments/Outcome
_____	_____	_____
_____	_____	_____

Any current medical diagnosis or diseases? Yes No

Diagnosis	Date	Comments/Status
_____	_____	_____
_____	_____	_____

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_____	_____	_____

May I contact physician(s) to co-ordinate treatment? Yes No

Signature: _____

Spouse/Partner #1 Clinical Information

Name: _____ Signature: _____

Please check all items that you have experienced in the last 6 months:

Physical Symptoms

- Headaches
- Fainting Spells/ Dizziness
- No appetite/Overeating
- Stomach/ Bowel disturbances
- Palpitations
- Tremors – shaking
- Poor sleep
- Nightmares/ Night Tremors
- Unusual bodily sensations
- Sexual Problems
- Tired/No Energy

Emotional Symptoms

- Anxious
- Depressed
- Self-Esteem Issues
- Fears/Worries
- Inferiority feelings
- Panic Attacks
- Anger Issues
- Feeling Tense/Stressed
- Shy
- Poor Decision Making
- Lack Ambition or Interests
- Unable to relax

Other _____

Social/Family Issues

- Marital/Partner problems
- Parent/Child problems
- Unemployed/Work Issues
- Financial Problems
- Court/Legal problems
- Problems making/keeping friends

Addictions

- Drinking problem
- Drug Abuse
- Gambling
- Sexual Addiction
- Food Addiction
- Excessive Shopping

Mental Health

- Previous Suicide Attempts
- Suicidal Ideas
- Visual Hallucinations
- Hearing Voices
- Disturbing thoughts or fears
- Manic

Please describe in detail those items checked above and for how long you have been experiencing each:

Spouse/Partner #2 Clinical Information

Name: _____ Signature: _____

Please check all items that you have experienced in the last 6 months:

Physical Symptoms

- Headaches
- Fainting Spells/ Dizziness
- No appetite/Overeating
- Stomach/ Bowel disturbances
- Palpitations
- Tremors – shaking
- Poor sleep
- Nightmares/ Night Tremors
- Unusual bodily sensations
- Sexual Problems
- Tired/No Energy

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