Family Therapy Center of Northern Virginia, llc

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Director, Gabrielle Anderson, lmft 703.350.1346

Client Information Form: Couples

Significant Other #1: _____

Address: _____

_____ Ok to mail items? Y/N

Home Phone: _____ OK to leave message? Y/N

Cell: _____ OK to leave message Y/N … Do you text? Y/N

Place of employment: _____

Position: _____

E-mail address _____ Checked regularly? _____

Do you want auto-reminders of appointments? Y/N… If Yes, by text or email?

(Circle one) If text, who is the cell phone carrier? _____

Date of birth: _____

Emergency contact:_____

Relationship to client: _____ Phone:_____

Please list any medications you currently take & why:_____

_____

Will you file for reimbursement? Y/N …If yes, which spouse will be "the patient"?

_____

Who referred you? _____ May I thank them? Y/N

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(Significant other #1)
Symptom Checklist **(please circle the appropriate response) Past = over 2 months ago**

1. Trouble falling asleep……Current Past Never
2. Trouble remaining asleep……..Current Past Never
3. Trouble getting out of bed……..Current Past Never
4. Loss of appetite……...Current Past Never
5. Excessive hunger……Current Past Never
6. Bingeing/purging……Current Past Never
7. Restrictive eating……Current Past Never
8. Excessive exercising……...Current Past Never
9. Trouble concentrating……Current Past Never
10. Excessive worrying……..Current Past Never
11. Frequent tearfulness……Current Past Never
12. Feelings of sadness……...Current Past Never
13. Irritability……Current Past Never
14. Physical aggression towards others……Current Past Never
15. Victim of physical aggression……..Current Past Never
16. Use of drugs/alcohol that is excessive……..Current Past Never
17. Use of drugs/alcohol that worries others……..Current Past Never
18. Hearing voices that others do not hear……Current Past Never
19. Seeing things others do not see……Current Past Never
20. Suicidal thoughts/attempts……...Current Past Never
21. Self-harm thoughts/actions……..Current Past Never
22. Homicidal thoughts/attempts……Current Past Never

Please briefly describe why you are seeking therapy today:

_____

_____

Please list any additional info: _____

_____

_____

Family Therapy Center Of Northern Virginia, llc

Client Information Form: Couples

Significant Other #2: _____

Address: _if same, leave blank_____

_____

Home Phone: _____ OK to leave message? Y/N

Cell: _____ OK to leave message Y/N … Do you text? Y/N

Place of employment: _____

Position: _____

E-mail address _____ Checked regularly? _____

Do you want auto-reminders of appointments? Y/N… If Yes, by text or email?

(Circle one) If text, who is the cell phone carrier? _____

Date of birth: _____

Emergency contact:_____

Relationship to client: _____ Phone:_____

Please list any medications you currently take & why:_____

_____

_____

Family Therapy Center Of Northern Virginia, llc

(Significant other #2)

Symptom Checklist **(please circle the appropriate response) Past = over 2 months ago**

1. Trouble falling asleep……Current Past Never
2. Trouble remaining asleep……..Current Past Never
3. Trouble getting out of bed……..Current Past Never
4. Loss of appetite……...Current Past Never
5. Excessive hunger……Current Past Never
6. Bingeing/purging……Current Past Never
7. Restrictive eating……Current Past Never
8. Excessive exercising……...Current Past Never
9. Trouble concentrating……Current Past Never
10. Excessive worrying……..Current Past Never
11. Frequent tearfulness……Current Past Never
12. Feelings of sadness……...Current Past Never
13. Irritability……Current Past Never
14. Physical aggression towards others……Current Past Never
15. Victim of physical aggression……..Current Past Never
16. Use of drugs/alcohol that is excessive……..Current Past Never
17. Use of drugs/alcohol that worries others……..Current Past Never
18. Hearing voices that others do not hear……Current Past Never
19. Seeing things others do not see……Current Past Never
20. Suicidal thoughts/attempts……...Current Past Never
21. Self-harm thoughts/actions……..Current Past Never
22. Homicidal thoughts/attempts……Current Past Never

Please briefly describe why you are seeking therapy today:

_____

_____

Please list any additional info: _____

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_____