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FAMILY & COUPLE QUESTIONNAIRE

Today's date: _____

Couple Information - Names: _____

Address: _____ City: _____ Zip Code: _____

Home Phone Number: _____ Cell Number (s) _____
(Okay to leave messages/texts at these numbers? _____)

Work Number (s): _____
(Ok to leave messages at these numbers? _____)

Emails: _____
(Okay to leave messages at these emails? _____)

Years married in current relationship: _____ or- Years in domestic partnership: _____

or- Years together as a committed couple: _____ Currently separated? ____ Yes ____ No

Adult 1: _____ Age: _____ Date of Birth: _____ Gender: _____

Occupation/Place of Employment: _____

Insurance (Name, Group #, Individual #): _____

Do you smoke: _____ If so, how much a day/week? _____

Do you use recreational drugs: _____ If so, what kind and how often do you use?

Do you use alcohol? _____ If so, how much a day/week?

Ever attended outpatient chemical dependency treatment? _____ If so, when? _____

Ever attended inpatient chemical dependency treatment? _____ If so, when? _____

Any pending legal issues? _____

Sleep issues? _____ Please describe: _____

Appetite/weight issues? _____ Please describe: _____

(Adult 1 continued)

Current physician (name and phone): _____

List all current medications, including dosage, when you take, how long you have been taking it, and what condition the medication was prescribed to treat:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Adult 2: _____ Age: _____ Date of Birth: _____ Gender: _____

Occupation/Place of Employment: _____

Insurance (Name, Group #, Individual #): _____

Do you smoke: _____ If so, how much a day/week? _____

Do you use recreational drugs: _____ If so, what kind and how often do you use?

Do you use alcohol? _____ If so, how much a day/week?

Ever attended outpatient chemical dependency treatment? _____ If so, when? _____

Ever attended inpatient chemical dependency treatment? _____ If so, when? _____

Any pending legal issues? _____

Sleep issues? _____ Please describe: _____

Appetite/weight issues? _____ Please describe: _____

Current physician (name and phone): _____

(Adult 2 continued)

List all current medications, including dosage, when you take, how long you have been taking it, and what condition the medication was prescribed to treat:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Children together/step/foster/adopted etc: Please list names, ages, grade & school, parents:

- _____ Age: _____ Grade/School: _____
- _____ Age: _____ Grade/School: _____
- _____ Age: _____ Grade/School: _____
- _____ Age: _____ Grade/School: _____
- _____ Age: _____ Grade/School: _____

1. Blended Family Relationships (number of marriages, children by other marriages, etc.)

2. Parenting Plan/Custody Issues? If yes, please explain:

(Please attach copy of current parenting plan to your Intake Information Packet)

3. Reason for today's visit:

4. Attempted solutions:

5. What are your goals for seeking treatment at this time?

6. Is there anything else you think I should know as we begin?