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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?

(Adult 1 continued)
Any current/past suicidal/homicidal thoughts/gestures? _______ If yes, please describe:

Any pending legal issues? _________

Sleep issues? _________ Please describe:

Appetite/weight issues? ________ Please describe:

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 current/past suicidal/homicidal thoughts/gestures? _______ If yes, please describe:

(Adult 2 continued)
Any pending legal issues? _________

Sleep issues? _________ Please describe:

Appetite/weight issues? ________ Please describe:

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. ____

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?