

## INITIAL COUPLE INTERVIEW

Please complete the following information. If you are unsure of any of it, feel free to leave it blank and bring it up during the opening interview. Thank You.

Today's Date \_\_\_\_\_

Name 1 \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Name 2 \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

H Phone \_\_\_\_\_ W Phone 1 \_\_\_\_\_ W Phone 2 \_\_\_\_\_

Cell 1 \_\_\_\_\_ Cell 2 \_\_\_\_\_

Occupation 1 \_\_\_\_\_ Employer 1 \_\_\_\_\_

Occupation 2 \_\_\_\_\_ Employer 2 \_\_\_\_\_

1 Check One:  Married  Lover/Companion  Single  Div/Sep

2 Check One:  Married  Lover/Companion  Single  Div/Sep

<p>1 Previous Therapy Experience? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", with whom? _____ Begun _____ Ended _____ Type of Psychotherapy: <input type="checkbox"/> Family <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Couple How were you referred to me? _____ Date _____ Your physician _____ Phone _____</p>	<p>2 Previous Therapy Experience? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", with whom? _____ Begun _____ Ended _____ Type of Psychotherapy: <input type="checkbox"/> Family <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Couple How were you referred to me? _____ Date _____ Your physician _____ Phone _____</p>
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