

**WHOLE HEALTH PLUS**  
**Couples Counseling Application**

**Internal Use Only**  
Today's Date & Time: \_\_\_\_\_  
DSM V, Axis I Code: \_\_\_\_\_  
Circle Type: I, C, F, G or Assessment Only

Partner 2's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address (If different than partner): \_\_\_\_\_

Preferred phone #: (please indicate if NOT okay to leave messages): \_\_\_\_\_

E-mail: \_\_\_\_\_ Place of work? \_\_\_\_\_

Emergency Contact (name & phone #): \_\_\_\_\_

Indicate all current physical health problems or medical diagnosis? \_\_aches/tension  
\_\_neck/back problems, \_\_organ or gland dysfunction i.e. liver, bladder, lung, skin  
\_\_allergies \_\_high blood pressure \_\_easily sick, \_\_other issues: \_\_\_\_\_

Please list current medications or supplements and what they are for:

Who prescribes your medicine or provides any additional treatment or help to you? \_\_\_\_\_

Any past or present legal, criminal or abuse/domestic violence involvement? Y/N?

Has anyone tried to hit or threaten you or make you feel unsafe? Y/N? Who? \_\_\_\_\_

Do you feel uncomfortable, unsafe or in danger by anyone currently? Y/N? If yes, do you have a safety or crisis plan or a trusted friend to stay with? \_\_\_\_\_

Any past or recent suicidal/homicidal thoughts, attempts or plans? Y/N? If yes, indicate dates, reasons and means. \_\_\_\_\_

Have any self-injurious behavior (i.e. cutting, bulimia), affairs or addictions (i.e. alcohol/drug abuse, pornography, gaming, phone, food)? \_\_\_\_\_

Indicate the year married, separated, divorced, etc.? \_\_\_\_\_

Have you been married before? Y/N? Has your partner been married before? Y/N?

If yes, indicate year and length? You: \_\_\_\_\_ Partner: \_\_\_\_\_

Children from any previous marriages? Y/N? If yes, how many and what ages?

Are there any other people living in your household? Y/N? If yes, who: \_\_\_\_\_

Do you or your partner have divorced and/or re-married parents? Y/N? Who? \_\_\_\_\_

Have you or your partner's parents or other significant family member passed away, abandon/left the family or distance themselves? Y/N? If yes, indicate who, when and if sudden? \_\_\_\_\_

**WHOLE HEALTH PLUS  
Counseling Application**

**Internal Use Only**  
Today's Date & Time: \_\_\_\_\_  
DSM V, Axis I Code: \_\_\_\_\_  
Circle Type: I, C, F, G or Assessment Only

Partner 1's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_

Preferred phone #: (indicate if NOT okay to leave messages): \_\_\_\_\_

E-mail: \_\_\_\_\_ Employed? Y/N?

Emergency contact (name, relationship & phone #): \_\_\_\_\_

Check if  Single  Married  In relationship  Separated  Divorced  
 Widowed  Engaged  Children or Pets? If yes, list names and what ages?

Indicate all current physical health problems or medical diagnosis?  aches/tension  
 neck/back problems,  organ or gland dysfunction (i.e. liver, bladder, lung, skin, reproductive, etc.)  allergies  high blood pressure  easily sick,  other issues:

Please list current medications or supplements and what they are for:

Who prescribes your medication or provides any additional treatment or help?

Any past and/or present legal, criminal or abuse involvement? Y/N?

Has anyone tried to hit or threaten you or make you feel unsafe? Y/N?

Do you feel uncomfortable, unsafe or in danger by anyone currently? Y/N?

If yes, do you have a safety/crisis plan or a trusted friend to stay with? Y/N?

Any past or recent suicidal or homicidal thoughts, attempts or plans? If yes, how many times, when & how? \_\_\_\_\_

Any self-injurious behaviors (i.e. cutting, bulimia) Y/N? or addictions (i.e. alcohol/drug abuse, pornography, gaming, phone, food)? \_\_\_\_\_

**SELF PAY OR CO-PAY due at time of visit. \$75/hour \$110/90 minutes**

Insured? Y/N? If yes, do they offer Mental Health Coverage? Y/N?

Indicate if someone other than you are responsible for payment and please sign a release and list name, e-mail and phone number of this third party: Y/N?