



South Riding Wellness Connection

A balanced approach to mental, physical, and spiritual health

Couple/Family Background Form

NAME: _____ DATE: _____

ADDRESS: _____

PHONE (Home): _____ (Work): _____ (Cell): _____

DATE OF BIRTH: _____

RACE/CULTURE (*Check all that apply*):

African African American Asian Asian American Caucasian
Hispanic Native American Pacific Islander Other: _____

RELIGION: _____ HIGHEST GRADE OF EDUCATION: _____

PRESENT MARITAL STATUS: Single Living together Engaged Married
 Separated Divorced Remarried Widowed

YOUR SPOUSE/PARTNER'S:

NAME: _____ RELIGION: _____ DOB: _____

RACE/CULTURE: *Check all that apply*

African African American Asian Asian American Caucasian
Hispanic Native American Pacific Islander Other: _____

HIGHEST GRADE OF EDUCATION: _____ Number of years married/together: _____

Were there any previous marriages for either spouse/partner? Yes No

How Many? Self: _____ Duration of each: _____ Partner: _____ Duration of each: _____

GROSS ANNUAL INCOME OF HOUSEHOLD: _____

WHO IS LIVING IN YOUR RESIDENCE?

Name	Age	Relationship

IN CASE OF AN EMERGENCY, THE CENTER FOR FAMILY SERVICES MAY CONTACT:

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

PHONE: Home: _____ Work: _____ Cell: _____

CHILDREN NOT LIVING AT HOME:

Name	Age

MEDICAL HISTORY:

Family Physician's Name: _____ Phone: _____

Do you or anyone in your family have any known medical problems, either current or past? If yes, please describe:

Are you or anyone in the family currently taking any medication? If yes, please provide information here:

Name of Person	Medication	Dosage	Prescribing Doctor	Yes / No Helpful?
				Yes/No Helpful?
				Yes / No Helpful?

FAMILY HISTORY:

Have there been any deaths in the immediate family? Please list by name and relationship and identify when these occurred.

Name of Deceased	Relationship to you	Date Occurred	Cause of Death

Has anyone in your family or your partner's family ever *attempted* suicide? If yes, please explain.

Does anyone in your family own weapons? No Yes
If yes, please list them and who owns them, where and how are they stored:

Type	Owner	Where/How stored?
Type	Owner	Where/How stored?

Has anyone in your family had previous counseling? (Dates, issues, helpful?)

Dates (From – To)	Provider	Issues	Yes / No Helpful?
Dates (From – To)	Provider	Issues	Yes / No Helpful?

Do you smoke? No Yes Amount per day _____

Please describe any concerns anyone in your family has ever expressed about another family member's use of:

Alcohol: _____

Other drugs: (Please list) _____

How much alcohol do you drink and how often? _____

Amount Per Day Frequency (Days / Week)

How much does your partner drink and how often? _____

Amount Per Day Frequency (Days / Week)

Which of these drugs, if any, have you used in the past year: (please check all applicable)

Marijuana Methamphetamine Other: _____

Cocaine Ecstasy Other: _____

Heroin Inhalants Other: _____

Has anyone ever expressed concern about the way in which anger is managed in your family? If yes, please explain or give example(s).

Has anyone in the family ever had conflicts that resulted in physical confrontation? For example: pushing, shoving, hitting, punching. If yes, please explain.

Have you or anyone in your family ever been involved in the court system? If yes, please explain.

Please state in your own words what you hope to accomplish in therapy:

HOW WERE YOU REFERRED TO US?

Name of referral source: _____ Title: _____

Agency: _____ Phone #: _____