

CLIENT INFORMATION - COUPLE

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Personal Information - Partner #1

Name: _____ Date: _____

Address: _____

Phone (msgs may be left): _____ E-mail*: _____

Birth Date: _____ Age: _____ Relationship Status: _____

Sex/Gender: _____ Sexual Orientation: _____

Religion/Spirituality: _____ Ethnicity: _____

SSN: _____ Occupation/Employer: _____

Emergency Contact: _____ Phone: _____
(Other than partner)

Medications: _____

Referred by: _____ May I thank her/him? Y N

Personal Information - Partner #2

Name: _____ Date: _____

Address: _____

Phone (msgs may be left): _____ E-mail*: _____

Birth Date: _____ Age: _____ Relationship Status: _____

Sex/Gender: _____ Sexual Orientation: _____

Religion/Spirituality: _____ Ethnicity: _____

SSN: _____ Occupation/Employer: _____

Emergency Contact: _____ Phone: _____
(Other than partner)

Medications: _____

Referred by: _____ May I thank her/him? Y N

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Relationship Information

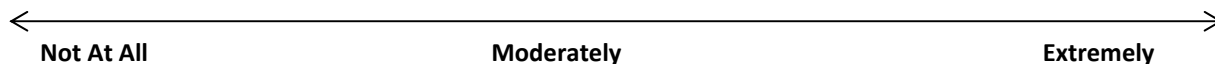
Current Relationship Status: _____ Length of Relationship: _____

Have you ever broken up or separated? _____ If yes, how many times? _____

Have you ever done any other couple's counseling? _____

Briefly describe the problem that is bringing you in: _____

How intense is this problem? (Partner #1 mark with X and Partner #2 mark with O)



What has already been done to address this? _____

What is the desired outcome in coming in? _____

Have either of you been previously married?

Partner #1: # of previous marriages: _____

Partner #2: # of previous marriages: _____

Divorce Finalized? Y N

Divorce Finalized? Y N

Divorce Reason(s): _____

Divorce Reason(s): _____

Do either of you have children from previous relationships?

Partner #1: # of children: _____ Names & Ages: _____

Custody/visitation arrangements (if any):

Partner #2: # of children: _____ Names & Ages: _____

Custody/visitation arrangements (if any):

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To Be Completed By Partner #1 Name: _____

<u>List 3 qualities you like <i>most</i> about your partner</u>	<u>List 3 qualities you like <i>least</i> about your partner</u>
1.	1.
2.	2.
3.	3.

<u>List 3 things you <i>like</i> doing with your partner</u>	<u>List 3 things you <i>don't like</i> doing with your partner</u>
1.	1.
2.	2.
3.	3.

<u>List 3 <i>strengths</i> your partner brings to the relationship</u>	<u>List 3 <i>strengths</i> you bring to the relationship</u>
1.	1.
2.	2.
3.	3.

Briefly describe any concerns you have about your partner's friendships, work habits, finances, health, coping skills, values, etc.:

List any "red flags" you had early in this relationship (even if they were ignored):

Describe efforts you have made to better your relationship:

Please list your specific goals for couple's therapy at this time:

- 1.
- 2.
- 3.

I, _____, give my written consent to share the information I have provided on this form with my partner, _____, during couple's therapy.

Partner #1 Signature: _____ Date: _____

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To Be Completed By Partner #2 Name: _____

List 3 qualities you like *most* about your partner

- 1.
- 2.
- 3.

List 3 qualities you like *least* about your partner

- 1.
- 2.
- 3.

List 3 things you *like* doing with your partner

- 1.
- 2.
- 3.

List 3 things you *don't like* doing with your partner

- 1.
- 2.
- 3.

List 3 *strengths* your partner brings to the relationship

- 1.
- 2.
- 3.

List 3 strengths you bring to the relationship

- 1.
- 2.
- 3.

Briefly describe any concerns you have about your partner's friendships, work habits, finances, health, coping skills, values, etc.:

List any "red flags" you had early in this relationship (even if they were ignored):

Describe efforts you have made to better your relationship:

Please list your specific goals for couple's therapy at this time:

- 1.
- 2.
- 3.

I, _____, give my written consent to share the information I have provided on this form with my partner, _____, during couple's therapy.

Partner #2 Signature: _____ Date: _____

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Additional Areas of Concern

As a couple, please check next to any of the issues below that are contributing to problems or concerns in your relationship.

	Abortion		Financial Troubles		Self-Esteem
	Abuse – Emotional		Friendship Problems		Self Injury
	Abuse – Physical		Gambling		Sexual Abuse/Assault
	Abuse – Verbal		Gender Identity		Sexual Arousal
	Adoption		Grief		Sexual Compulsive Behaviors
	Alcohol Use/Misuse		Health Concerns		Sexual Desire Differences
	Anger		Hostility		Sexual Orientation
	Anxiety/Nervousness		Impulsiveness		Sexual Pain or Discomfort
	Career concerns		Infidelity/Cheating		Sexual Performance
	Childhood issues		Irritability		Shyness
	Children/Family Planning		Lacking Love & Affection		Sleep
	Concentration		Laziness		Smoking/Tobacco Use
	Communication		Legal Matters		Spirituality
	Crying		Loneliness		Stress
	Debt		Loss of Interest in Activities		Suicidal Thoughts, Plan or Intent
	Dependence		Loss of Interest in Sex		Temper Problems
	Depression		Mood Swings		Violence or Threats of Violence
	Divorce/Separation		Motivation		Weight/Body Image
	Domestic Violence		Nightmares		Work Issues
	Drug Use/Misuse		Obsessions/Compulsions		Other concerns or issues:
	Eating Concerns		Orgasm Issues		
	Education/School		Panic or Anxiety Attacks		
	Fatigue		Pornography Use		
	Fears or Phobias		Relationship Problems		