Therese Noël Allen, MA, MFT, License #46690
Phone: 415.307.3043 Email: therese@thereseallenmft.com
www.thereseallenmft.com

Couples Therapy - New Client Information

This form is for each partner to complete one copy of and submit to me. (Between the two of you, you will submit two copies of this form). Your answers to these questions will give me a quick view into a spectrum of parts of your life and relationship. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments. I encourage you to bring up any areas I haven't asked about.

Name: _____ Pronoun: _____

Legal name (if different): _____

Date of Birth: _____

Present
Address:_____
Street *City* *State* *Zip*

Phone: _____ Email: _____

Who do you authorize me to contact and disclose any necessary information to ensure your safety in an emergency?
Name: _____ Relationship: _____

Address: _____

Phone: (Cell) _____ (Home/Work)_____

Please describe medical care you are receiving, including any medications or supplements you take:

_____

_____

Please briefly describe what led to your choice to work with me.

_____

_____

_____

How would you describe a typical fight between you and your partner? (Try answering without seeking your partner's perspective or sharing yours.)

What part of the fight is the most painful for you? (See if you can describe concrete behaviors, rather than ideas about how your partner feels or motivations.)

What do you love about your partner? (Rather than giving a logical answer, take a moment to notice what brings up the most feeling of tenderness or love in your body)

What do you hope to come from our work together? Please be specific (i.e., rather than "to have a better relationship", please describe what your relationship would be like if it was better).

Using the scale below, please choose a number that reflects the extent of your concern about each issue, whether **personally (P)** or **in your relationship (R)**. Please rate every item.

0 1 2 3 4 5 6 7 8 9 10
No Minimal Concern Moderate Concern Extreme Concern

P R

__ __ Anger/aggression

__ __ Religious/spiritual

__ __ Depression/feeling sad

__ __ Sex/intimacy

__ __ Impacts of abuse/violence/trauma

__ __ Thoughts of suicide

__ __ Eating or body image

__ __ Feeling frozen/numb/vacant

__ __ Fearfulness

__ __ Parenting

__ __ Sleep

__ __ Use of alcohol/drugs

P R

__ __ Sexual orientation

__ __ Gender identity/transition

__ __ Loved one's drug/alcohol use

__ __ Partnership/relationship

__ __ Nervousness/Anxiety

__ __ Physical/health/disability

__ __ Work/employment

__ __ Social relationships/friends

__ __ Relationship(s) with family

__ __ Grief/loss

__ __ Finances

__ __ Other (specific)