Rachel Benson, Licensed Clinical Social Worker, Inc.
Individual, Couples, & Group Psychotherapy

Client Information Sheet (Couples Therapy)

The information requested on this form is confidential.
Please have EACH partner in the couple complete a copy of this form and bring them to your first session.

Today's Date: ________________

Person 1

Name: ____

Mailing Address: ____

City: ____ State: _________ Zip: _________________

Telephone numbers: home:____________________cell:_________________________work _______________
Is it okay to leave confidential messages at the above numbers? Yes No (circle one)

Birthdate: _______________ Age: ___________ Gender: ___Maile ___Female

Email Address: ____
May I email you? ____Yes ____ No ***Please note: Email is not considered to be a confidential medium of communication.

EMPLOYMENT

Employer: ____ Occupation: ___________________________

Employment address: ____

FAMILY HISTORY

Father: ___Living ___Deceased Current age or age at time of death: ____ Cause of death: ______________

Mother: ___Living ___Deceased Current age or age at time of death: ____ Cause of death: ______________

Females Only: Have you ever been pregnant? Yes No (circle one) If yes, what year(s)?_____________________

Females Only: Are you currently pregnant? Yes No (circle one) If yes, what is your due date?_____________________

Children – How many __________ Names & Ages____

SPIRITUALITY

Do you consider yourself to be spiritual and/or religious? Yes No (Circle one) If yes, describe your faith or belief:

____

IN CASE OF EMERGENCY,
PLEASE CONTACT: ____ ***PHONE:*** ____________________
Name and relationship

RACHEL BENSON
LCSW

Person 1

PSYCHOTHERAPY, MEDICAL, AND MEDICATION HISTORY

Have you ever sought psychotherapy or counseling before? Yes No (circle one)

If so, when? ______________________________ For how long? ____

Please list all medications you are currently using: ____

____

Apart from those medications listed above, have you ever used any of the following:

Anti-depressants	Yes	No (circle one)	Anti-anxiety meds	Yes	No
Appetite suppressants	Yes	No	Laxatives	Yes	No
Sedatives	Yes	No	Muscle relaxants	Yes	No
Pain medication	Yes	No			

Have you ever been hospitalized for any reason? Yes No (circle one)

If yes, when? _____________________________ For how long? ____

If yes, please explain the situation: ____

Do you have any current or past medical issues? Yes No (circle one)

If yes, please explain: ____

Are you currently experiencing overwhelming sadness, grief, or depression? Yes No

Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No

Do you drink alcohol more than once a week? Yes No

How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

ADDITIONAL INFORMATION

My partner and I are currently: (circle all that apply) Dating Engaged Married Separated Divorced

How long have you been in your current relationship? ____________________________________

On a scale from 1-10, how would you rate your current relationship? ____________

How do you identify your gender?_________________ What is your sexual orientation? _____________________________

What significant life changes or stressful events have you experienced recently?

____

____

What would you like to accomplish out of your time in therapy?

____

RACHEL BENSON
LCSW

Person 2

Name: ____

Mailing Address: ____

City: ____ State: _______ Zip: _______________

Telephone numbers: home:_______________ cell:_____________________work _____________
Is it okay to leave confidential messages at the above numbers? Yes No (circle one)

Birthdate: ______________ Age: __________ Gender: ___Maile ___Female

Email Address: ____
May I email you? ____Yes ____ No ***Please note: Email is not considered to be a confidential medium of communication.

EMPLOYMENT

Employer: ____________________________________ Occupation: _______________________

Employment address: ____

FAMILY HISTORY

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PLEASE CONTACT: **__________________________________ PHONE: ________________**
Name and relationship

PSYCHOTHERAPY, MEDICAL, AND MEDICATION HISTORY

Have you ever sought psychotherapy or counseling before? Yes No (circle one)

If so, when? _______________________ For how long? ________________________________

Please list all medications you are currently using: _____________________________________

____

PERSON 2

Apart from those medications listed on the previous page, have you ever used any of the following:

Anti-depressants	Yes	No (circle one)	Anti-anxiety meds	Yes	No
Appetite suppressants	Yes	No	Laxatives	Yes	No
Sedatives	Yes	No	Muscle relaxants	Yes	No
Pain medication	Yes	No			

Have you ever been hospitalized for any reason? Yes No (circle one)

If yes, when? ___________________________ For how long? ____

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How do you identify your gender?________________ What is your sexual orientation? __________________________

What significant life changes or stressful events have you experienced recently?

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____

What would you like to accomplish out of your time in therapy?

____

CANCELLATION POLICY

To avoid being charged for a cancelled session, the session must be cancelled at least 24 hours in advance by leaving a message at (714)-468-3685. Sessions cancelled with less than 24 hours notice will be charged at the full fee. By law, insurance providers may not reimburse patients for fees paid for cancelled sessions.

POLICY AND LAWS REGARDING CONFIDENTIALITY

All information between patient and therapist is held in strict confidence. The only exception to this is that state law requires all mental health providers to report suspected child or elder abuse, and allows for breach of confidentiality if patients disclose a likelihood to be of danger to themselves or others.

I have read the foregoing and my signature below attests to my understanding of these policies.

___________________________________ _______________________

Signature (Person 1) **Date**

___________________________________ _______________________

Signature (Person 2) **Date**