Alliance Counseling Services
950 Corporate Peninsula Circle, Suite 3002
Boca Raton, FL, 33487

Paperwork for Partner #1

Please review, sign, and bring these documents to our first appointment, or email prior to, if you prefer.
Please complete one intake packet for each person participating in couples counseling.

<table>
<tr><td colspan="2">Name:</td><td>Birth Date:
/ /
mm dd yy</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td>Gender:</td><td>Work/Cell Phone #:</td><td rowspan="2">Emergency Contact:
Name: _____
Relationship: _____
Phone #: _____
Address: _____
_____</td></tr>
<tr><td>Highest Leve of Education:</td><td>Number of moves in past 5 years:</td></tr>
</table>

Relationship status: _____ Length of time in current relationship: _____

Have you been married before? (Yes / No) If yes, number of marriages: _____

How long have you been currently married (if applicable?): _____

How long have you and your partner been living together (if applicable?): _____

Partner's name _____ Age _____ Quality of Rel. (1 low – 10 high) _____

Hometown: _____

How long have you been in South Florida? _____

Do you consider yourself to be a spiritual person? (Yes / No)

Religious identification: _____ Level of importance (1 low – 10 high): _____

What is your current occupation? _____

Place of employment: _____

How long at current position? _____ Do you enjoy what you do for a living? _____

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What is the career you've always dreamed of? _____

Family Information:

Mother's Name: _____ Age: _____ Quality of Rel. (1-10) _____

Father's Name: _____ Age: _____ Quality of Rel. (1-10) _____

Paternal (dad's side) grandparents (names and ages): _____

Maternal (mom's side) grandparents (names and ages): _____

Siblings – please list all brothers and sisters:

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Children:

Number of living children: _____ Number of pregnancies: _____ Sexually active? Y / N

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

History of mental health issues for you or your family: _____

History of sexual, physical or emotional abuse: _____

Did you have a best friend when you were growing up? _____

Have you ever attempted suicide? _____ Any current thoughts of suicide? _____

Please describe any self-harm without intending suicide: _____

Have you ever been violent towards others? _____ Any current thoughts of harm to others? _____

Do you have any medical concerns/conditions? _____

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Are you currently taking any medications? Yes / No

Please list all medications: _____

Are you now or have you ever seen a psychiatrist? _____

Name and telephone of your primary physician: _____

May we contact your physician? _____

Number of emergency room visits in the past five years: _____

Have you experienced any losses or setbacks recently? If so, please explain: _____

_____

Experience with previous counseling (inpatient/outpatient?): _____

_____

If you won the lottery, what are the first three things you would do with the money?

_____

_____

Please answer the below information to help me understand your relationship concerns:

What relationship concerns bring you to counseling? _____

_____

How did you and your partner meet? _____

_____

At the beginning of your relationship, who pursued whom? _____

Did these relationships change over time? Who is the pursuer now? _____

_____

What initially attracted you to your partner? _____

_____

What deepened the attraction with your partner to a feeling of love? _____

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_____

What do you like most about your partner today? _____

_____

Please describe any history of physical aggression or violence in your relationship. _____

_____

Do you have any concerns about alcohol, drugs, or other addictions regarding yourself or your partner? If yes, please describe: _____

_____

In the spaces provided, please rate:

The level of trust I have in my partner				
1 Low	2	3 Neutral	4	5 High
The level of emotional support I feel in this relationship				
1 Low	2	3 Neutral	4	5 High
The level of (non-sexual) affection we display toward each other				
1 Low	2	3 Neutral	4	5 High
The level of conflict or distressing arguments in our relationship				
1 Low	2	3 Neutral	4	5 High
The level of emotional and physical distance in our relationship				
1 Low	2	3 Neutral	4	5 High
I believe that I usually come first in my partner's life				
1 Low	2	3 Neutral	4	5 High
I often feel lonely or shut out in our relationship				
1 Low	2	3 Neutral	4	5 High
I feel that my partner is usually there for me in our relationship				
1 Low	2	3 Neutral	4	5 High
I feel that I can lean on my partner for support				
1 Low	2	3 Neutral	4	5 High
I generally feel a strong sense of connection with my partner				
1 Low	2	3 Neutral	4	5 High

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How do you express love and affection in your relationship? _____

_____

How do you prefer to be shown love and affection in your relationship? _____

_____

When couples distressed, it is normal to fall into a predictable pattern of arguing; having "the same argument 500 different ways." This is draining, frustrating, and hurtful, and is often expressed through complaining, blaming, defensiveness, fighting, distancing, etc.

How would you describe the distressing pattern in your relationship? _____

_____

When I'm upset, I show it to my partner by: _____

_____

I can tell that my partner is upset when: _____

_____

I tend to express my needs (circle only one) Directly Indirectly Not at All

The more I *(e.g. complain, express my needs, or feelings)* _____, the more my partner *(e.g. distances, yells at me, etc.)* _____, and as a result I _____. When this happens, I feel _____ and my partner feels _____.

I hereby consent to be treated and have been informed of the limitations and risks:

_____ _____
Signature *Date*

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Paperwork for Partner #2

Please review, sign, and bring these documents to our first appointment, or email prior to, if you prefer.
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mm dd yy</td></tr>
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Relationship status: _____ Length of time in current relationship: _____

Have you been married before? (Yes / No) If yes, number of marriages: _____

How long have you been currently married (if applicable?): _____

How long have you and your partner been living together (if applicable?): _____

Partner's name _____ Age _____ Quality of Rel. (1 low – 10 high) _____

Hometown: _____

How long have you been in South Florida? _____

Do you consider yourself to be a spiritual person? (Yes / No)

Religious identification: _____ Level of importance (1 low – 10 high): _____

What is your current occupation? _____

Place of employment: _____

How long at current position? _____ Do you enjoy what you do for a living? _____

What is the career you've always dreamed of? _____

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Family Information:

Mother's Name: _____ Age: _____ Quality of Rel. (1-10) _____

Father's Name: _____ Age: _____ Quality of Rel. (1-10) _____

Paternal (dad's side) grandparents (names and ages): _____

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Siblings – please list all brothers and sisters:

Name: _____ Age: _____ Quality of Rel. (1-10) _____

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Children:

Number of living children: _____ Number of pregnancies: _____ Sexually active? Y / N

Name: _____ Age: _____ Quality of Rel. (1-10) _____

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Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

History of mental health issues for you or your family: _____

History of sexual, physical or emotional abuse: _____

Did you have a best friend when you were growing up? _____

Have you ever attempted suicide? _____ Any current thoughts of suicide? _____

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Have you ever been violent towards others? _____ Any current thoughts of harm to others? _____

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Please list all medications: _____

Are you now or have you ever seen a psychiatrist? _____

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Experience with previous counseling (inpatient/outpatient?): _____

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If you won the lottery, what are the first three things you would do with the money?

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Please answer the below information to help me understand your relationship concerns:

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I tend to express my needs (circle only one) Directly Indirectly Not at All

The more I *(e.g. complain, express my needs, or feelings)* _____, the more my partner *(e.g. distances, yells at me, etc.)* _____, and as a result I _____. When this happens, I feel _____ and my partner feels _____.

We are strongly influence by the relationships we experienced growing up. Please describe your childhood experiences with your parents and other significant people in your early life.

Parents: _____

_____

Siblings: _____

_____

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What did you need most that you didn't get while growing up? _____

_____

Who could you rely on growing up? _____

_____

How were you emotionally supported, and by whom? _____

_____

Other comments about your childhood relationships: _____

_____

I hereby consent to be treated and have been informed of the limitations and risks:

_____ _____
Signature *Date*