Mina Law-Glassman, LMFT 8 Corporate Park, Ste 300 Irvine, CA 92606
. (949)533-0665 mlawmft@hotmail.com License# mfc47369

Client Information - Couples Counseling

Date: _____
Name:_____
Address:_____. City: _____State: _____ ZIP_____
Phone Numbers: Home: (_____)_____ Work: (_____)_____
Cell: (_____)_____
Email: _____ SSN: _____-_____-_____
Birth date: _____. CA Driver's License#_____

Marital /Relationship Status: (circle one) Single/ Married/ Domestic Partner/ Divorced
How long together:_____
Work Status: (circle one) Employed /Full-time Student /Part-time Student /Other
Employer_____
_____
Primary Care Physician: _____Phone: (_____)_____
Emergency Contact: _____ Phone: (_____)_____
Who referred you:_____

Children- list names and ages:
_____
_____
_____
_____
Date of your last doctor appointment:
_____
Major Medical Injuries, Illnesses, or Surgeries: approximate dates_____
_____
_____
_____
List any current medications you are taking (name, dosage, prescribing MD, appx start date):
_____
_____

Health Insurance coverage for Mental health: if any, list coverage information:
_____
_____

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Any specific Psychotropic medications you are taking currently or in the past year (name, dosage, prescribing MD):

Please list any substances you use such as, alcohol, marijuana, caffeine, tobacco, etc, and approximate frequency):

Please list any couples or individual therapist you have seen in the past: (appx dates)

List any psychiatric disorders in immediate or extended family- eg. Depression, bipolar, schizophrenia?

Describe your current support system (family, friends, organizations, etc.):

What areas/problems do you want to address in couples counseling:

What are the strengths you bring to your relationship/marriage?

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What are the weaknesses you bring to your relationship/marriage?

What are the strengths your partner brings to the marriage/relationship?

What are the weaknesses your partner brings?

What are the changes you wish to see happen with the help of couples counseling?

Signature Date