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TODAY'S DATE: _____

YOUR INFORMATION

Name:
Age: Address:
City: State: Zip:
Home Phone: Business Phone:
Mobile #: Email Address:
Profession:
Number Years Married to Current Spouse:
Children's Names and Ages:
Previous Marriage(s) & Length of Marriage(s):

SPOUSE'S INFORMATION

Spouse's Name:
Spouse's Address:
City: State: Zip:
Spouse's Age:
Spouse's Previous Marriage(s) & Number Years Previously Married:
Spouse's Health:
Spouse's Profession:

YOUR FAMILY OF ORIGIN

Mother's Name: Mother's Profession:
Father's Name Father's Profession:
Mother's Age: Mother's Location:
Father's Age: Father's Location:
Mother's Health:
Father's Health:

Write 3 positive adjectives to describe your Mother:
(1) _____
(2) _____
(3) _____

Write 3 negative adjectives to describe your mother:
(1) _____
(2) _____
(3) _____

Write 3 adjectives to describe your Father:
(1) _____
(2) _____
(3) _____

Write 3 negative adjectives to describe your Father:
(1) _____
(2) _____
(3) _____

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Please provide a list of therapists you are currently seeing (if any). For each, include their role, and whether Lisa has permission to contact him or her if need be.

CURRENT PROBLEM/ISSUES - Please provide description of current problems and issues to be addressed:

HEALTH CHECKLIST - Check all that apply to each family member and yourself

	You	Spouse	Children	Briefly Explain
Anxiety	☐	☐	☐	
Depression	☐	☐	☐	
Drinking	☐	☐	☐	
Substance Abuse	☐	☐	☐	
Anger	☐	☐	☐	
Workaholism	☐	☐	☐	
Food Addiction	☐	☐	☐	
Spending/Gambling	☐	☐	☐	
Sex Addiction	☐	☐	☐	
Physical Health	☐	☐	☐	

ADDITIONAL INFORMATION

I would like each of you attending the session to send a one-page summary to me giving background information and your desired outcomes for the session. Please limit your response to a single page.