Lillybrook
In Times of Struggle, We Are Here

PARTNER RELATIONAL
PERSONAL HISTORY INFORMATION

ACCT#:_____

******TO BE FILLED OUT BY EACH PARTY IN THE RELATIONSHIP***
PLEASE PRINT CLEARLY

Today's Date_____ Readmit: ____Yes ____No

_____
Last Name First Name Middle Initial

_____
Street Address City State Zip

Date of Birth_____

_____ _____
Phone Number Work Number

_____ _____
Name of Spouse/Significant Other Spouse/Significant Other Phone Number

EMERGENCY CONTACTS:

Primary Physician: _____ Phone #: _____

Other: _____Specialty: _____ Phone #: _____

EMPLOYMENT INFORMATION:

Employer: _____ Occupation: _____ Hrs.: _____

REFERRAL SOURCE:

How did you hear of our clinic? _____

Address: _____

Phone Number: _____

To assist us in helping you, please fill out the attached information as fully and as openly as possible. Your answers will help plan the course of therapy that is most suitable for you and your significant other. Please do not collaborate with your significant other when completing this form. Please respond honestly and carefully to each item. If certain questions do not apply, please state that as your answer. Use extra sheets if necessary.

FAMILY/DEVELOPMENTAL INFORMATION
Information regarding your parents:

			Living		Living with you	
	Name	**Age**	**Yes**	**No**	**Yes**	**No**
Mother						
Father						

- ☐ Parent legally married
- ☐ Parents ever separated
- ☐ Parents divorced (If yes, how long have your parents been divorced?) _____
- ☐ Mother remarried: Number of times _____
- ☐ Father Remarried: Number of times _____

Information regarding Children: Use additional pages if necessary)
Answer options for "Whose Child*" section below:

B Both of ours, natural child
BA Both of ours, adopted (or taken on)
M My natural child
MA My child, adopted (or taken on)
S Spouse's natural child
SA Spouses child, adopted (or taken on)

Child's Name	Age	Sex	Whose Child*	Living		Living with you	
				Yes	No	Yes	No

Significant Others (Brothers, Sisters, Grandparents, Step-relative, Half-relatives):

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No

Marital Status

- ☐ Single
- ☐ Unmarried: Living with significant other
- ☐ Engaged: Wedding date: _____
- ☐ Legally married: Length of time: _____
  - o Is this your first marriage? ____ Yes ____ No
  - o If no, how many times have you been married? _____
- ☐ Separated: Length of time? _____
  - o How many times have you and your spouse separated? _____
- ☐ Annulment: Length of time: _____
- ☐ Divorce in progress
- ☐ Divorce: Length of time: _____
- ☐ Widowed: Length of time: _____

Were you involved in a significant relationship in the past that did not work out? ____ Yes ____ No

Assessment of current relationship? ___ Excellent ___Good ___Fair ___Poor

Do you believe your relationship can improve ___Yes ___No

On a scale of 1 (not at all) to 10 (very willing), rate your willingness to work on improving your relationship: _____

Any special circumstances of your current relationship (domestic violence, pornography, etc.):

_____

_____

_____

Please write a paragraph describing your life growing up. Include circumstances that affected your development: (child abuse, sexual abuse, inadequate nutrition, neglect, relocation, etc.)

_____

_____

_____

_____

_____

_____

SOCIAL INFORMATION

Describe how you relate to people (i.e. easily, shy, leader, follower, extrovert, etc.).

_____

_____

Who do you socialize with (immediate family, extended family, friends, co-workers, etc.)?

_____

_____

Who is your main source of emotional support (family, friend, co-worker, no-one, etc.)? _____

Do you and your significant other have the same friends? ___Yes ___No Separate friends? ___Yes ___No

Do you isolate yourself from other people? ___Yes ___No

Explain:

_____

_____

_____

Is your spouse included in your socialization? ___Yes ___No

Describe special interests or hobbies you may have (art, music, crafts, outdoor activity, church activity, books/films, physical fitness, diet/health, sports, etc.): _____

_____

Has your activity level changed recently? ___Yes ___No If yes, please explain: _____

_____

_____

_____

Do you feel the social aspect of your life has created conflict in your relationship? ___Yes ___No

Sexual Orientation (Heterosexual, homosexual, bisexual, etc.): _____

List any sexual problems, concerns, or difficulties you may be experiencing: _____

_____

_____

Do you feel this is an area of concern in your relationship? ___Yes ___No

SPIRITUAL/RELIGIOUS INFORMATION

Do you consider yourself a spiritual person? ___Yes ___No

What religion were you raised? _____

Do you practice a formal religion now? ___Yes ___No If yes, what religion? _____

Do you feel your spiritual/religious beliefs currently cause conflict in your relationship? ___Yes ___No

LEGAL INFORMATION

Current Legal Information

Are you involved in an y active cases (traffic, civil, criminal): ___Yes ___No

If yes, please describe and indicate the court dates and charges: _____

_____

_____

Are you presently on probation or parole: ___Yes ___No If yes, please describe: _____

_____

_____

Past Legal History

Please describe any past legal issues: _____

_____

_____

_____

Are you currently, or have you ever been, involved in any child custody cases? ___Yes ___No If yes, please give further details regarding this: _____

_____

_____

Are you currently ordered to pay child support? ___Yes ___No

EDUCATION INFORMATION

Check all that apply

- ☐ High school diploma/GED
- ☐ Currently enrolled: Last grade completed: _____

- ☐ Did not complete high school: Last grade completed: _____
- ☐ College:
  - Currently enrolled: Number of years completed: _____
  - Degree(s) earned: _____
- ☐ Vocational school/training:
  - Currently enrolled: Number of years completed: _____
  - Training completed: Specialty: _____

Special circumstances (i.e. learning disabilities, gifted program, special education, etc.): _____

_____

Do you feel the education difference (if any) between you and your significant other have created conflict in your relationship?

___Yes ___No Explain: _____

_____

EMPLOYMENT/VOCATIONAL INFORMATION

Beginning with your most recent job, give employment history; include homemaker experience (include extra sheets if necessary):

Employer	Dates	Job Description	Salary

Total yearly income: $_____ Total Family Income: $_____

Special circumstances (laid off, self-employed, suspended, disabled, retired, social security, etc.) _____

_____

Is your significant other employed? ___Yes ___No If yes, please state their occupation: _____

Is employment a source of conflict in your relationship? ___Yes ___No

Are finances a source of conflict in your relationship? ___Yes ___No

PHYSICIAL HEALTH INFORMATION

Check all that apply

☐ Abdominal Pain	☐ Dizziness	☐ Miscarriages
☐ Abortion	☐ Epilepsy	☐ Neurological Disorders
☐ Allergies	☐ Eating Problems	☐ Sexual Transmitted Diseases
☐ Asthma	☐ Fatigue	☐ Sleeping Disorders
☐ Bed Wetting	☐ Hepatitis	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Sexual Problems
☐ Chest Pain	☐ HIV	☐ Substance Abuse
☐ Chronic Pain	☐ Kidney Problems	☐ Thyroid Problems

☐ Diabetes	☐ Menstrual Pain	☐ Other: _____

Explain: _____

_____

_____

_____

Please list any current medications you are taking (prescription and over the counter):

_____

_____

_____

Are you allergic to any medications or drugs? If yes, please describe: _____

_____

_____

	Date	**Reason**	**Result**
Last Physical			
Last doctor's visit			

List any surgeries and dates: _____

_____

List any family history of medical problems: _____

_____

Any recent changes in:

- ☐ Sleep pattern - If yes, describe: _____
- ☐ Eating patterns - If yes, describe: _____
- ☐ Behavior - If yes, describe: _____
- ☐ Energy level - If yes, describe: _____
- ☐ Physical activity level - If yes, describe: _____
- ☐ General disposition - If yes, describe: _____
- ☐ Weight - If yes, describe: _____
- ☐ Increase in nervousness or tension - If yes, describe: _____
- ☐ Other: _____. Please describe: _____

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours	Used in last 30 days

					Yes	No	Yes	No
Alcohol								
Barbiturates								
Caffeine								
Cocaine/Crack								
Heroin/Opiates								
Inhalants								
Marijuana								
Nicotine								
Over the counter								
PCP/LSD/Mescaline								
Prescription Drugs								
Valium								
Other drugs								

Substance of preference: _____

Does your significant other use drugs or abuse substances of any kind? ___Yes ___No If yes, describe: _____

_____

_____

COUNSELING/PRIOR TREATMENT INFORMATION

Information about yourself:

	Yes	No	When	Where	Briefly Describe
Relational/Marital Counseling					
Individual Counseling/Psychiatric Treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-help groups (i.e. AA, Al-Anon, NA, Overeaters Anonymous, Celebrate Recovery)					

Information about your significant other:

	Yes	No	When	Where	Briefly Describe

Relational/Marital Counseling					
Individual Counseling/Psychiatric Treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-help groups (i.e. AA, Al-Anon, NA, Overeaters Anonymous, Celebrate Recovery)					

Information about your family:

	Yes	No	When	Where	Briefly Describe
Relational/Marital Counseling					
Individual Counseling/Psychiatric Treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-help groups (i.e. AA, Al-Anon, NA, Overeaters Anonymous, Celebrate Recovery)					

What are your goals for therapy? _____

_____

_____

_____

Do you feel suicidal at this time? ___Yes ___No

CLIENT SIGNATURE_____ DATE_____

STAFF USE ONLY

The information contained within this form was reviewed and discussed with the patient as deemed necessary.

_____ _____Therapist

Signature/Credentials (if not completed through the client portal) Date

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