Thomas Joseph Doherty, Psy.D.
Licensed Psychologist

ADULT PATIENT INFORMATION – COUPLES

Partner 1: ______________________________ Today's Date: ______________

Gender: M _____ F _____ Age: _____ Birth Date: ______________ SSN: ______________

Address: ______________________________ City, State, Zip: ______________

Telephone(s): ______________ ______________ ______________ ______________
(home) (cell) (work) partner (work)

e-mail: ______________________________

May we leave messages for you? ❑ on home phone ❑ on work phone ❑ on email ❑ other _________ ❑ No

Partner 2: ______________________________

Gender: M _____ F _____ Age: _____ Birth Date: ______________ SSN: ______________

Address: ______________________________ City, State, Zip: ______________

Telephone(s): ______________ ______________ ______________ ______________
(home) (cell) (work) partner (work)

e-mail: ______________________________

May we leave messages for you? ❑ on home phone ❑ on work phone ❑ on email ❑ other _________ ❑ No

❑ Others living in the home:

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:

Emergency contact: ______________Phone: ______________Relationship: ______________

Referred by: ______________________________

	Education	Occupation	Employer
Partner 1			
Partner 2			

Insurance Information (If using insurance, ATTACH COPY OF INSURANCE CARD)

	Primary	Secondary
Insured Name.	____________________	____________________
Date of Birth	____________________	____________________
	____________________	____________________
Insurance ID No.	____________________	____________________
Relationship to Patient .	____________________	____________________
Address	____________________	____________________
City, State, Zip	____________________	____________________
Employer		
Insurance Company Name.	____________________	____________________
Address	____________________	____________________
Phone	____________________	____________________
Other Information:		

Insurance Authorization: I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

______________________________ ______________
Partner 1 or Authorized Person's Signature Date

______________________________ ______________
Partner 2 or Authorized Person's Signature Date

Person(s) Financially Responsible for Treatment:

______________________________ ______________
Date

______________________________ ______________
Date

PARTNER 1: STRENGTHS & ISSUES:

Describe the problem(s) that brought you here today:

What is going well in your life?

Check any of the symptoms that you are having:				This space reserved for additional comments by clinician:
Depression		Feeling hopeless		
Extreme sadness		Feeling tearful		
Trouble concentrating		Change in sleeping habits		
Memory problems		Lack of energy		
Change in eating habits		Weight changes		
Feeling of extreme happiness		Change in sexual interest or function		
Trouble performing your job		Problems getting along with friends or family		
Lack of enjoyment of usual activities		Feeling stressed		
Self-esteem problems		Easily irritated		
Perfectionism		Feeling guilty		
Obsessions or compulsions		Feeling nervous		
Feeling fearful		Sudden feelings of panic		
Physical complaints of pain		Muscle tension		
Problems with anger		Acting violently		
Thoughts of hurting yourself or others		Thoughts of killing yourself or others		

Partner 1 Continued:

HAVE YOU EVER BEEN IN COUNSELING BEFORE? **Yes [ ]** **No [ ]**

If you have been in counseling before, please describe it below. Start with the most recent time first.

A When did you have counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	
B When did you have counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	

PARTNER 1: MEDICAL INFORMATION

Have you seen a doctor within the last year?	Yes [ ]	No [ ]
Why have you seen a doctor?		
Who is your doctor?	Phone:	
Are you taking any medications, prescription or over-the-counter? Please Describe:	Yes [ ]	No [ ]
Do you have allergies to anything? Please describe:	Yes [ ]	No [ ]

PARTNER 1: SUBSTANCE USE HISTORY

Do you use/ have you used tobacco (any form)?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used alcohol?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used caffeine (any form, including cola drinks)?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used other mind-altering substances (drugs)?	Current [ ]	Past [ ]	No [ ]

PARTNER 2: STRENGTHS & ISSUES:

Describe the problem(s) that brought you here today:

What is going well in your life?

Check any of the symptoms that you are having:				This space reserved for additional comments by clinician:
Depression		Feeling hopeless		
Extreme sadness		Feeling tearful		
Trouble concentrating		Change in sleeping habits		
Memory problems		Lack of energy		
Change in eating habits		Weight changes		
Feeling of extreme happiness		Change in sexual interest or function		
Trouble performing your job		Problems getting along with friends or family		
Lack of enjoyment of usual activities		Feeling stressed		
Self-esteem problems		Easily irritated		
Perfectionism		Feeling guilty		
Obsessions or compulsions		Feeling nervous		
Feeling fearful		Sudden feelings of panic		
Physical complaints of pain		Muscle tension		
Problems with anger		Acting violently		
Thoughts of hurting yourself or others		Thoughts of killing yourself or others		

Partner 2 Continued:

HAVE YOU EVER BEEN IN COUNSELING BEFORE? Yes [ ] No [ ]

If you have been in counseling before, please describe it below. Start with the most recent time first.

A When did you have counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	
B When did you have counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	

PARTNER 2: MEDICAL INFORMATION

Have you seen a doctor within the last year?	Yes [ ]	No [ ]
Why have you seen a doctor?		
Who is your doctor?	Phone:	
Are you taking any medications, prescription or over-the-counter? Please Describe:	Yes [ ]	No [ ]
Do you have allergies to anything? Please describe:	Yes [ ]	No [ ]

PARTNER 2: SUBSTANCE USE HISTORY

Do you use/ have you used tobacco (any form)?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used alcohol?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used caffeine (any form, including cola drinks)?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used other mind-altering substances (drugs)?	Current [ ]	Past [ ]	No [ ]