Caroline LaRosa, L.C.S.W.
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Thank you in advance for your time in completing this confidential questionnaire. The information will help me understand your situation. When added to our meetings together, it will help us find an effective approach to the challenges we shall be considering together. Your replies will be held in confidence as required by law.

Please add any information that you believe might be relevant, using the reverse sides of pages if necessary.

Name_____ Age_____ Date of Birth_____

Address _____City_____ Zip_____

Phone numbers: Home _____ Work_____

Do you authorize permission to call home phone number? Yes_____ No_____

Do you authorize permission to call work phone number? Yes_____ No_____

May I leave a message? Yes_____ No_____ If not, please specify which numbers_____

Occupation _____

Referred by: _____

In case of an Emergency, I should contact:

Name _____ Phone_____

Address _____ City_____ Zip_____

Relation_____

Please describe the reasons for coming to couples therapy at this time _____

_____

_____

_____

_____

_____

FAMILY INFORMATION

While it is impossible to create a form that will describe every family, I hope to better understand your situation through the completion of your family information. Feel free to add explanations or other information that you think would help provide an accurate picture of your family.

Spouse(s): Name Age Years married/Year divorced Current City/State of residence

1._____

2._____

3._____

4._____

Children: Name Age Years married/Year divorced Current City/State of residence

1._____

2._____

3._____

4._____

5._____

Parents:

Mother's name: _____ Age: _____ Living? Yes ___ No ___

Occupation (current or prior): _____ Cause of death, if deceased:_____

If living, where?: _____ Married to other parent?: Yes ___ No ___

Remarried: Yes ___ No ___

Father's name: _____ Age: _____ Living? Yes ___ No ___

Occupation (current or prior): _____ Cause of death, if deceased:_____

If living, where?: _____ Married to other parent?: Yes ___ No ___

Remarried: Yes ___ No ___

Sibling(s): Name Age Current City/State of residence

1._____

2. _____

3. _____

4. _____

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License # 7674

Other significant family members, family you are especially close to, live or lived with, etc.:

1._____

2._____

3._____

4._____

Have any family members had problems:

With alcohol? Yes ___ No ___ How related? _____

With drugs? Yes ___ No ___ How related? _____

With their mental health? Yes ___ No ___ How related? _____

Attempted or committed suicide? Yes ___ No ___ How related? _____

Please circle any concerns which pertain to you:

Nervousness	Depression	Fears
Sleeping	Sexual Problems	Suicide Thoughts
Eating Problem	Alcohol-Drug Use	Friends
Finances	Stress	Employment Issue
Legal Matters	Memory/Concentration	Perfectionism
Self-Control	Inferiority Feelings	Unclear Self-Image
Self-Confidence	Career Choices	Health Problems
Anger	Nightmares	Marriage
Children	Parents	Sexual Orientation
Guilt	Making Decisions	Thoughts
Fearing Failure	Feeling Empty	Anxiety
Breakup of Relationship	Feeling Worthless	Self-Esteem
Communication	Hopelessness	Panic
Obsession/Compulsion	Hearing Voices	Weight
Relationship Issues	Seeing Strange Things	Body Image
Spirituality	Resentment	Grief and Loss

Previous Therapist(s) **Reason Seen** **Date of Services**

Medication History

Which medications are you taking now (medical or psychiatric)?

Drug Dose Frequency Prescribing physician

Which medications have you taken in the past?

Drug Date Reason for discontinuing

CONSENT TO TREATMENT

I consent to psychotherapeutic evaluation and treatment. I have received a client handbook and agree with the terms stated therin.

Signature **Date**

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