Dana Falls, Marriage and Family Therapist, MFT 29714
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5755 Mountain Hawk Dr., Ste. 201
Santa Rosa, CA 95409
Telephone 707-696-6138, Fax 707-525-9009

Client Information

First Name	Last Name	Birth Date	Age	Gender

Street Address	City	State	Zip

Home Phone	Cell Phone	Email

Person to notify in case of emergency

Occupation	Ethnicity	Referred by

Relationship Information

Are you currently in a relationship yes no

If yes: Married (years) Domestic Partnership (years) Dating (years)

If No: Have you been in a long- term relationship? Y N (years)

Questions for Couples Therapy

Has there ever been or is there currently and domestic violence (Physical Abuse) occurring in your relationship_________________?

If Yes, describe____

____.

What would you most like to get out of our work together?

Describe your previous individual or couple therapy experience if any:

____

Attraction Phase: Describe falling in love with your partner. What were the traits he/she possessed that made you decide to connect with him/her.

Power Struggle: (Challenges we face now…)____________________________________

What do you imagine it is like being in a relationship with you?________________

What are the strengths of this relationship**?**________________________________

Is there anything else I need to know about you and your relationship that would be important so that I can be the most helpful? I cannot hold secrets from your partner, but I can help you tell them things you might be afraid to say to them.

____

If we were to be wildly successful in our work together, what would your relationship look like and feel like when we are finished?

What am I doing that is keeping me from having the relationship that I long for?

What is one thing that I can do differently to create the relationship that I want?

Medical Information

How many times in your life have you been hospitalized overnight for a medical condition?

Do you have any chronic conditions that continue to interfere with your life?

Are you taking any prescription medication on a regular basis? Y N

If yes: Please list medication(s) for their condition(s) below___________________________________

Have you experienced any medical conditions in last 30 days?________________________________

When was your last Medical Exam?____

Has anyone in your family committed suicide? Yes__________ No______________

If Yes: Whom? _____________________________________ When? ___________________________________

Have you ever attempted suicide? Yes__________________ No_______________

If Yes: When was your last attempt? ____

Are you currently having thoughts of committing suicide? Yes_____________ No______________

Drug or Alcohol Use

What is your current drug or alcohol use, including frequency?

Substance Used **Amount (per week)**

Alcohol____

Caffine____

Tobacco____

Marijuana____

Cocaine/Crack____

Inhalants____

LSD____

Heroin____

Ecstasy____

Prescription Medication____

Other____

How long was your last period of voluntary abstinence from this substance?

____

Have you ever been treated for alcohol or drug abuse or attended any 12 step programs for any type of abuse or compulsion?

____.

Thank you for your honesty and thoughtfulness in answering these questions. Please scan (danafallsmft@gmail.com) or fax (707 525-9009) the documents back to me. If you do not have access to these devices, please bring the completed forms to your first session.