*from*Within
COUNSELING | Equipping. Empowering. Encouraging.

Couples Counseling Registration */ 3 pages*

1) PARTNER

Name _____ Email _____

Date of Birth _____ Preferred method of contact _____

Address _____ Age / Gender / Religious Affiliation _____

City, State and Zip _____ Occupation _____

Home Phone _____ Employer _____

Mobile Phone _____ Work Phone _____

2) PARTNER

Name _____ Email _____

Date of Birth _____ Preferred method of contact _____

Address _____ Age / Gender / Religious Affiliation _____

City, State and Zip _____ Occupation _____

Home Phone _____ Employer _____

Mobile Phone _____ Work Phone _____

3) RELATIONSHIP STATUS

O Dating O Engaged O Cohabitating O Married (___ yrs) O Divorced O Separated

Name of child (or children)	Age(s)	School / Grade(s)

* If children are stepsiblings (s) or partial siblings (ps) please indicate next to their name.

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Briefly describe your reason for seeking couples counseling

List strengths of your relationship

List weaknesses of your relationship

How would you know that your time in therapy has been successful—what would look different in your relationship?

Partner 1: _____

Please circle all that currently apply:

Nervousness	**Lack of Self-Esteem**	**Suicidal Thoughts**
Depression	**Financial Concerns**	**Chronic Pain**
Stress	**Sexual Compulsivity**	**Abuse/Domestic Violence**
Loss/Greif	**Alcohol Use Problems**	**Problems at Work**
Difficulty Sleeping	**Drug Use Problems**	**Friendship Concerns**
Loneliness	**Recent Weight Loss/Gain**	**Anxiety/Fears**
Anger	**Nausea/Abdominal Stress**	**Panic Attacks**
Parenting Problems	**Difficulty Concentrating**	**Health Concerns**
Relationship Problems	**Racing Thoughts**	**Concerns About Body Image**
Separation	**Significant Mood Swings**	**Eating Disorder**
Pornography Use	**Headaches**	**Faith Concerns**

Partner 2: _____

Please circle all that currently apply:

Nervousness	**Lack of Self-Esteem**	**Suicidal Thoughts**
Depression	**Financial Concerns**	**Chronic Pain**
Stress	**Sexual Compulsivity**	**Abuse/Domestic Violence**
Loss/Greif	**Alcohol Use Problems**	**Problems at Work**
Difficulty Sleeping	**Drug Use Problems**	**Friendship Concerns**
Loneliness	**Recent Weight Loss/Gain**	**Anxiety/Fears**
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Relationship Problems	**Racing Thoughts**	**Concerns About Body Image**
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615.298.9595 842 Tyne Boulevard, Nashville, TN 37220 mailing address: 4815 Franklin Pike contact@fromwithin-counseling.com

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Have either of you had previous counseling (individual or couples)? ○ Yes ○ No

Name of therapist(s) / Date(s) of counseling

Name of therapist(s) / Date(s) of counseling

Would you be willing to sign a release of information for me to talk with your previous counselor(s)? ○ Yes ○ No

4) REFERRAL INFORMATION

It is my regular practice to thank those who refer clients to me.
Would you be willing to share their name? ○ Yes ○ No

Referred by

○ Family Member ○ Friend ○ Counselor ○ Physician ○ Agency ○ Church ○ Internet

Can I share your name with the person who referred you? ○ Yes ○ No

5) EMERGENCY CONTACT

Name / Relationship with this Person:

Cell Phone

Home Phone

Work Phone

6) ACKNOWLEDGE

► I have received and read *From Within's* policy and procedure information / *please initial* _____

► I understand that all appointments not cancelled with 24 business hours notice will be charged a full counseling hour rate / *please initial* _____

► I understand that payment is due at the time of service / *please initial* _____

Client Signature / Date

Client Signature / Date

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