WRIGHT WELLNESS
www.wrightwellness.me
1398 W. Mayfield Rd., Suite 220
Arlington, TX 76015
office@wrightwellness.me
682.777.4325

PATIENT INFORMATION (Couples/Family)

To be completed by each individual. Please note that while you will be asked to talk about your answers in sessions, your partner or family member will not be shown this form.

Today's date: _____/_____/_____

Identification

Legal Name:_____ Age:_____Date of Birth:____/____/_____

Preferred Name:_____Sex (only required for insurance):_____

Gender Identity: _____Preferred Pronouns:_____

Race & Ethnicity:_____

Race & Ethnicity Details: _____Preferred Language:_____

Home street address:_____

City/State/Zip:_____

Phone (Primary):_____ Email: _____

Calls/texts/e-mails will be discreet, but please indicate any restrictions:_____

Occupation /Employment status:_____

Military Experience:_____Education:_____

Relationship status: ❑ Married ❑ Separated ❑ Divorced ❑ Living Together ❑ Living Apart

❑ Dating ❑ Single ❑ Other: _____

Children: _____

_____

Closest Relationships

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Emergency Contact

If an emergency arises and we cannot reach you directly and we need to reach someone close to you, whom should we call? By listing someone below, you give permission for them to be contacted in the case of an emergency:

#1 Name: _____

Phone: _____ Relationship: _____

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Address: _____

#2 Name: _____

Phone: _____ Relationship: _____

Address: _____

Medical Care (A signed release is required for treatment coordination)

Primary Care Provider_____

Location/Phone_____

Legal History

Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No If yes, please explain:

_____

Is your reason for coming to see us related to an accident or injury? ❑ Yes ❑ No If yes, please explain:

_____

Are you required by a court, the police, or a probation/parole officer to have this appointment?

❑ Yes ❑ No If yes, please explain: _____

Have you every had to file a complaint or been involved in a lawsuit with another mental health professional? ❑ Yes ❑ No If yes, please explain:

_____

Any other legal involvement or history? _____

_____

For minors, has this minor been named in a custody agreement, court order, and/or divorce decree? ❑ Yes ❑ No If yes, please provide a copy of this document along with other standard paperwork and all applicable adults will be contacted in accordance with this agreement. Failure to provide this information initially will result in services being stopped until documentation is obtained.

Treatment and Symptom History

I. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling (individual or couples) services before? ❑ No ❑ Yes If yes, please indicate:

What kind? _____When?_____

From whom? _____

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For what? _____

With what results? _____

Reason for stopping treatment? _____

II. Do you have a **history** of taking medications for psychiatric or emotional problems?

❑ No ❑ Yes If yes, please indicate:

What medications? _____

_____

When?_____

From whom? _____

For what? _____

With what results? _____

Reason for stopping treatment? _____

Do you ***currently*** take medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

What medications? _____

_____

From whom? _____

For what? _____

For how long? _____

With what results? _____

III. Do you have a history of abuse/neglect or any other kind of trauma, including complex trauma, and/or is there any history of violence in your relationship?

❑ No ❑ Yes If yes, please describe what you are willing to:

_____

_____

_____

IV. Are you currently concerned about abuse or dependency of a substance and/or a behavioral addiction for yourself or your partner/family member? ❑ No ❑ Yes If yes, please provide details about your current use and/or behaviors including amount, frequency, and reasons for use/behavior:

_____

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_____

_____

V. Risk Assessment
Do you have a **history** of suicidal thoughts or attempted suicide in the past? ❑ No ❑ Yes If yes, please describe when and the circumstances: _____

_____

_____

Are you **currently** experiencing suicidal or homicidal thoughts? ❑ No ❑ Yes
Do you have a specific plan? ❑ No ❑ Yes If yes, please explain:

_____

_____

Please check **all** MEDICAL conditions you **have had** or **are having**:

❑ AIDS/HIV Positive
❑ Alcoholism
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Bleeding Disorder
❑ Brain Injury
❑ Bronchitis
❑ Bulimia
❑ Cancer
❑ Cataracts
❑ Congestive Heart Failure
❑ Chicken Pox
❑ Dementia
❑ Diabetes
❑ Emphysema
❑ Epilepsy/Seizures
❑ Glaucoma
❑ Goiter
❑ Gout
❑ Heart disease
❑ Hepatitis
❑ Hernia
❑ Herpes
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Disease
❑ Liver Disease
❑ Measles
❑ Meningitis
❑ Migraine Headaches
❑ Mononucleosis
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Parkinson's Disorder
❑ Pelvic Inflammatory
❑ Pneumonia
❑ Polio
❑ Prostate problems
❑ Rheumatic Fever
❑ Scoliosis
❑ Sexually Transmitted Disease
❑ Stroke
❑ Thyroid Problems
❑ Tuberculosis
❑ Ulcers
❑ UTIs
❑ Other: _____
❑ Other: _____
❑ Other: _____
❑ Other: _____
❑ Other: _____

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Please check all **past** and **present** PSYCHIATRIC/PSYCHOLOGICAL diagnoses.

- ❑ ADHD/ADD
- ❑ Agoraphobia
- ❑ Alcohol Abuse or Dependence
- ❑ Anorexia
- ❑ Anxiety Disorder
- ❑ Bipolar Disorder
- ❑ Bulimia
- ❑ Depression
- ❑ Eating Disorder
- ❑ Generalized Anxiety
- ❑ Learning Disorder
- ❑ Intellectual Disability
- ❑ Obsessive Compulsive Disorder (OCD)
- ❑ Panic Disorder
- ❑ Personality Disorder
- ❑ Posttraumatic Stress Disorder
- ❑ Psychosis
- ❑ Schizophrenia
- ❑ Substance Abuse or Dependence
- ❑ Behavioral Addiction (gambling, etc)
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

Please check any **current symptoms or experiences** you have had within the last month and/or have prompted you to seek services.

- ❑ Excessive worry
- ❑ Excessive anxiety
- ❑ Very nervous
- ❑ Muscle tension
- ❑ Sleep disturbance
- ❑ Pounding heart
- ❑ Accelerated heart rate
- ❑ Shortness of breath
- ❑ Nausea or upset stomach
- ❑ Fear of losing control or of "going crazy"
- ❑ Fear of dying
- ❑ Numbness or tingling in lips/fingertips
- ❑ Obsessive thoughts
- ❑ Compulsive behavior
- ❑ Phobias/Fears
- ❑ Rituals
- ❑ Depressed mood
- ❑ Irritable mood
- ❑ Fighting and arguing
- ❑ Watchful/aware
- ❑ Startle easily
- ❑ Elevated mood
- ❑ Euphoric mood
- ❑ Mood swings
- ❑ Decreased need for sleep
- ❑ More talkative than usual
- ❑ Racing thoughts
- ❑ Increase in activity
- ❑ Excessive spending
- ❑ Hearing voices
- ❑ Seeing visions or other people/objects
- ❑ Unusual beliefs
- ❑ Increased sadness
- ❑ Frequent crying
- ❑ Loss of interest or pleasure in activities
- ❑ Weight loss/gain
- ❑ Insomnia
- ❑ Hypersomnia
- ❑ Trouble concentrating
- ❑ Increased indecision
- ❑ Drinking more
- ❑ Smoking more
- ❑ Eating more
- ❑ Eating less
- ❑ Change in sex drive or satisfaction
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

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Chief Concern

How can we help? Please describe the main difficulty that has brought you to see us: _____

_____

_____

_____

_____

_____

What are your strengths as a couple/family?: _____

_____

_____

For couples, please answer the following additional questions:

Have either of you threatened to separate or divorce (if married) as a result of the current relationship problem? ❑ Yes ❑ No If yes, who? ❑ Me ❑ Partner ❑ Both of us

If married, have either you or your partner consulted with a lawyer about divorce? ❑ Yes ❑ No

If yes, who? ❑ Me ❑ Partner ❑ Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? ❑ Yes ❑ No
If yes, who? ❑ Me ❑ Partner ❑ Both of us

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner/family member does:

_____

_____

Please answer the following questions, with 1=extremely unpleasant/unhappy/high stress and 10=extremely pleasant/happy/no stress:

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10

How satisfied are you with the frequency of your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10

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What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10

Please rank the order of the top three concerns you have in your relationship with your partner and include what you have already tried to address these difficulties if applicable (1 being the most problematic):

1. _____

_____

2. _____

_____

3. _____

_____

Who Referred you?

Name: _____

Phone: _____

Email: _____

May we have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how we might be of help to you? _____

Other: ❑ Internet ❑ Psychology Today ❑ Insurance

Intake Notes (for staff only):

_____

_____

_____

_____

_____

_____