# Burt Bertram, Ed.D.

Licensed Marriage and Family Therapist (0145)
Licensed Mental Health Counselor (0863)

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## Couple Information & History

Date: _____ Referred by: _____

| Spouse/Partner #1 | Spouse/Partner #2 |
|---|---|
| Name: | Name: |
| Address: | Address: |
| Phone: (Permission to text: ☐ Yes / ☐ No)<br>• Cell:<br>• Other(s): | Phone: (Permission to text: ☐ Yes / ☐ No)<br>• Cell:<br>• Other(s): |
| Email: | Email: |
| Age: Date of Birth: | Age: Date of Birth: |
| Race/Ethnicity: Gender: | Race/Ethnicity: Gender: |
| Education: | Education: |
| Occupation: | Occupation: |
| Marital Status:<br>Date Married _____ Length of Relationship_____ Years | Marital Status:<br>Date Married _____<br>Length of Relationship_____ Years |
| Previous Marriages? | Previous Marriages? |

**Family Information**

| Children | Age | at home Y/N | Children | Age | at home Y/N |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**The Problem** – What are the most obvious difficulties that brought you to counseling?

_____

_____

_____

_____

**Primary Goal** - What is your Primary Goal for counseling? _____

_____

_____

_____

**What Has Changed** - Please describe any major recent changes in your personal or work life.

**Previous Counseling** – Please list (Individually or Couples) and with whom and when.

**Trauma** - Have there been any significant emotional traumas in your life, past or present?

| Spouse/Partner #1 | Spouse/Partner #2 |
|---|---|
| | |

**Other Stressors** - What other stressors (emotional, health, financial, legal, employment, losses/deaths etc.) are affecting your current state of mind that your counselor should know?

| Spouse/Partner #1 | Spouse/Partner #2 |
|---|---|
| | |

**Faith Traditions** - Is there a faith/religion/spiritual tradition or practice that is important to you?

| Spouse/Partner #1 | Spouse/Partner #2 |
|---|---|
| | |

**Mental Health Medications** - Are you now, or have you in the past, taken medication for depression, anxiety or any other condition related to your mental or emotional wellbeing?

| Spouse/Partner #1 | Spouse/Partner #2 |
|---|---|
| If Yes, please list medications and name of prescribing physician. | If Yes, please list medications and name of prescribing physician. |

**Health** - Please describe your general health including any specific health conditions that may have a bearing on your emotional wellbeing.

| Spouse/Partner #1 | Spouse/Partner #2 |
|---|---|
| Primary Care Physician<br>_____<br>Phone | Primary Care Physician<br>_____<br>Phone |

**Payment for Services**: Who is responsible for payment?

☐ Client Couple
☐ Other: Please provide contact information for the other
Name: _____
Address _____
Phone(s) _____
Email _____

Payment is appreciated at the end of each counseling session and can be made by check, credit card or cash.