

Ariella Goodwine Fisher, M.S., LMFT
Co-Parenting
Client Information

Name: _____ Today's Date: _____

Date of Birth: _____ email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: cell: _____ okay to leave a message? yes ___ no___

home: _____ okay to leave a message? yes ___ no___

work: _____ okay to leave a message? yes ___ no___

Emergency Contact #1: _____

Relationship: _____

Phone #: _____

Emergency Contact #2: _____

Relationship: _____

Phone #: _____

Employer: _____

Are you currently working with a psychotherapist? yes ___ no___

Length of marriage (or, if never married, length of relationship w/ co-parent): _____

Names and ages of children: _____

Do you have a history of substance abuse and/or dependence? If yes, please describe.

Has the court ordered co-parent counseling? If so, please provide the relevant specifics of the order (or a copy of the order itself):

Describe the quality of the co-parenting relationship to date:

Describe the kind of co-parenting relationship you hope to have going forward:

In the past 3 months, have you experienced any of the following symptoms at a level that you would consider significant? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Phobias/Fears |
| <input type="checkbox"/> Avoidance | <input type="checkbox"/> Self-destructive relationships |
| <input type="checkbox"/> Compulsive Behavior | <input type="checkbox"/> Self-harm behaviors or impulses (i.e. cutting/burning) |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Physical symptoms |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Guilt/self-blame | <input type="checkbox"/> Sleep problems (sleeping too much/not enough) |
| <input type="checkbox"/> Harm to others/threats to others | <input type="checkbox"/> Disordered eating symptoms |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Other: _____ |

If you would like to describe any of the above symptoms further, please do so here: