Michael Sherman, MFT

Couples Information Sheet

Name _____ **Date of Birth** _____

Address _____ **Social Security #** _____

City _____ **Zip Code** _____

Telephone Home _____ **Work** _____

Cell Phone/Other _____

Occupation/Employer _____

Medication(s)/Dosage _____

_____

Any prior counseling or therapy? Dates? Therapist(s) _____

_____

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_____

Length of Relationship _____ **Current Status** _____

Names/Ages of any children _____

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