Harmony Healing Cindy Ostuni, LCSW-R and Kathleen Tryon, LCSW-R

Office Phone: 315-436-5428 Fax: 315-422-2022

Confidential Personal Record

Date		SS#		
Name		Date of Birth	Age	
Address				
Home Phone Number		Can we leave a	Can we leave a message? Yes No	
Work Phone Number		Can we leave a i	message? Yes No	
Employer				
Address				
Who referred	d you to us?			
	<u>Fa</u>	mily History:		
1.	What is your relationship status? Sing	gle Dating Marri	ed Domestic Partner	
	Divorced Widow(er)			
2.	What is your partner's name?		Age	
3.	Do you have children? Yes No _			
	Names and ages of children			
4.	With whom do you live?			
5.	How many brothers and sisters do you have?			
6.	Are you the oldest, youngest, or middle child?			
7.	Have you been married before and/or have you lived with another significant partner in the past?			
	Yes No Name		Age	
8.	What is your religion?			
9.	Medication(s) you take:			

10.	Previous individual or couples' therapy:		
11.	Alcohol and drug history:		
12.	Anything else you could tell me that would help me to help you now? (Loss of any kind, trauma in		
	the relationship, life circumstance that is challenging or had been challenging, significant transitions, etc.)		
13.	Falling in love: Tell me how you met and what attracted you to your partner.		
14.	Power Struggle: (Things changed when)		
15.	What I imagine it is like to be married (in partnership) with me is		

16.	What I see as the strengths of our relationship are
17.	If we are wildly successful in our work together, the qualities that will be present in our relationship are
18.	What I am doing now that is keeping me from having those qualities is
19.	Some things I could begin to do that would move us toward having the relationship I long for are