CALIFORNIA STATE UNIVERSITY, LONG BEACH
COMMUNITY CLINIC FOR COUNSELING AND EDUCATIONAL SERVICES
1250 Bellflower Boulevard, ED2-155
Long Beach, CA 90840
Tele: (562) 985-4991
Fax: (562) 985-1469

Couple's Application
Information Questionnaire
All information will be treated with strict confidentiality

Date:_____

Name of Applicant 1:_____

Name of Applicant 2:_____

Date of Birth Applicant 1: _____ Age:_____ Sex: Male Female

Date of Birth Applicant 2: _____ Age:_____ Sex: Male Female

Applicant 1

Primary language:_____ Secondary language:_____

Racial/ethnic background:_____

Address:_____

Home phone: _____Cell phone:_____

Office or work phone:_____ Email:_____

May we leave you a message on your home/cell phone? Would you like to sign up for our email update?

Yes No Yes No

Marital status:_____ # times married:_____ # of years in current marriage:_____

Occupation:_____ Employer:_____

Education: Are you currently a CSULB student? Yes No

For Office Use Only

Notice of application received: _____ Notes: _____

Reviewed for: _____ Confirmed Waitlisted Not Accepted Date called:

Reviewed for: _____ ☐ Confirmed ☐ Waitlisted ☐ Not Accepted Date called:

How did you hear about the Clinic?_____

Please list any major health problems: _____

_____

Please list any medications you take:_____

_____

Have you been in therapy before? ☐ Yes ☐ No

If yes, when? _____Reason:_____

_____

Whom did you see? _____Did it help? ☐ Yes ☐ No ☐ Some

What do you hope to get out of this consultation or therapy?_____

_____

Do you have any current/past legal issues? If yes, please explain. *(Note: we cannot serve court mandated cases).*

_____

_____

Applicant 2

Primary language:_____ Secondary language:_____

Racial/ethnic background:_____

Address:_____

Home phone: _____Cell phone:_____

Office or work phone:_____ Email:_____

May we leave you a message on your home/cell phone? Would you like to sign up for our email update?

How many children are currently living with you?_____

How many individuals are currently living in your home?_____

Please check or circle any of the following that are currently troubling you:

inferiority feelings	children	loneliness	headaches	phobias	tiredness
sexual problems	shyness	education	insomnia	extreme fatigue	sadness
suicidal thoughts	separation	guilt	agoraphobia	panic attacks	nervousness
making decisions	drug use/abuse	bowel trouble	appetite	overweight	fetishes
health problems	anger	depression	fears	sexual abuse	conflict
stomach trouble	sleep	divorce	finances	abused as a child	self-esteem
career choices	relaxation	alcohol use	friends	battered/beaten	homicidal
concentration	no interests	compulsions	confidence	painful thoughts	temper
being a parent	energy	self-control	unhappiness	ACOA	impotence
marriage	legal matters	ambition	stress	legal problems	work

Please describe briefly your reasons for seeking psychological consultation or therapy:_____

_____

What do you hope to get out of this consultation or therapy?_____

_____

Do you have any current/past legal issues? If yes, please explain. *(Note: we cannot serve court mandated cases).*

_____

_____

Client signature 1: _____

Client signature 2: _____