COUPLES INTAKE FORM

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office. Leave blank any questions you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Date:_____

Name: _____ Age:_____ DOB:_____

Your Spouse/Partner:_____ Age:_____ DOB:_____

Address:_____

Home Phone: ( ) - May I leave a msg? □ Yes □ No

Cell/Other Phone: ( ) - May I leave a msg? □ Yes □ No

E-mail:_____ - May I email you? □ Yes □ No

Referred by: _____

Can I thank them for connecting you with me? □ Yes □ No

Relationship Status: (check all that apply)

□Married □Separated □Divorced □Dating □Living Together □Living Apart

Length of time in current relationship:

Number of Children: _____

Names and ages of children:

Have you had previous therapy? □ No □ Yes, previous therapist's name: _____

What was the outcome (check one)?

□Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

OCCUPATIONAL/SCHOOL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position?_____

If yes, are you happy at your current position?_____

Are you currently a student? □ No □ Yes, school's name: _____

Please list any work-related/school stressors, if any:_____

HEALTH INFORMATION:

1. In the last year, have you experienced any significant life changes or stressors? If yes, please explain._____

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you currently taking prescribed psychiatric medication (antidepressants or others)? □ No □ Yes If Yes, please list:

_____

4. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams

□Other_____

5. Are you having any difficulty with appetite or eating habits? □No □Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past? □ Frequently □Sometimes □ Rarely □Never

7. Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?
□ Yes □ No If yes, how often?
Do either you or your partner use marijuana?
□ Yes □ No If yes, how often?

8. Have either you or your partner struck, physically restrained, used violence against or injured the other person? □ Yes □ No
If yes for either, who, how often, and what happened?
_____

9. How many hours do you spend using the internet per day?
Work/School: _____ Social Media: _____ YouTube:_____ Netflix/TV:_____ Gaming:_____

SPIRITUAL INFORMATION:

Is spirituality part of your life? □Yes □ No
If yes, what is your faith/spiritual beliefs and practices?
Could spirituality discussions be part of the counseling process? □ Yes □ No□

RELATIONSHIPS:

1. Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship:
1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

2. Have either of you threatened to separate or divorce (if married) as a result of the current relationship concerns? □ Yes □ No If yes, who? ___Me ___ Partner ___Both of Us

3. Do you perceive that either you or your partner has withdrawn from the relationship?
□ Yes □ No If yes, which of you has withdrawn? _Me ___Partner ___Both of Us

4. What do you hope to accomplish through counseling?

5. What are some effective coping strategies that you've learned?

6. Check each of the following areas of challenge you are currently or have experienced within the past 6 months.

□ Affection □ Holding other back □ Sexual Issues □ Agreeing on chores
□ Housing □ Showing appreciation □ Closeness □ Infidelity
□ Solving problems together □ Common Goals □ In-laws
□ Spouses/partner's cleanliness □ Common interests □ Jealousy
□ Trusting each other □ Communication □ Parenting □ Use of time
□ Finances □ Physical fighting □ Verbal fighting □ Friendships
□ Recreation □ Guilt / Shame □ Relatives □ Future Planning
□ Detrimental use of pornography

7. Which of these problems, issues or questions do you wish to address in counseling at this time? Why now?

8. Which of these problems are you primarily responsible for and which are the responsibility of others? Who are these other persons?

9. Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

10. From whom do you receive support and encouragement?

11. What are your biggest strengths as a couple?