Intake Form – Couple

First Name	Last Name	Today's Date

Birth Date	Age	Gender	Sexual Orientation
/ /			

Cell Phone	Ok to leave message?	Home Phone	Ok to leave message?	Work Phone	Ok to leave message?
	Yes No		Yes No		Yes No

Street Address	City	State	Zip

Email address	May I email you?
	Yes No

Name of Partner:	Length of relationship:
	_____years, _____months

Relationship Status (circle all that apply):

Dating Cohabiting Married Living Together Living Apart Separated Divorced

Partner's Birth Date	Partner's Age	Partner's Gender	Partner's Sexual Orientation
/ /			

Cell Phone	Ok to leave message?	Home Phone	Ok to leave message?	Work Phone	Ok to leave message?
	Yes No		Yes No		Yes No

Address if not living together:

Email address	May we email you?
	Yes No

Emergency contact, other than your partner: (name, number, relationship to you)

Referred by (if any):

Please provide the following information about your children and household.

Child	Sex	Age	Name (Optional)	If the child is not a product of the current relationship, please list details (i.e., adopted, foster child, one partner's child from another relationship, etc.)
1st	M F	____	_____	_____
2nd	M F	____	_____	_____
3rd	M F	____	_____	_____
4th	M F	____	_____	_____
5th	M F	____	_____	_____

Who lives in your house with you?

_____

What do you each do for work?

_____

Have you received prior couples counseling? □ Yes □ No
If yes, when: _____ Where: _____
By whom: _____ Length of treatment: _____
Issues Addressed: _____
_____

What was the outcome (check one)?
□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in *individual* counseling before?
If yes for either, who, and give a brief summary of concerns that you addressed.
_____
_____
_____

Do either you or your partner drink alcohol or use drugs recreationally?
If yes for either, who, how often and which drugs or alcohol?
_____
_____
_____

Have either of you received help for drug or alcohol dependency?
If yes, Who?_____ When? _____ For what?_____
Where?_____

Have either of you been hospitalized for mental/emotional/psychiatric reasons?
If yes, Who?_____ When? _____ For what? _____
Where?_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?
If yes for either, who, how often and what happened?
_____
_____
_____

Have either of you threatened to separate or divorce (if married) as a result of the current relationship problems?
If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?
If yes, who? ___Me ___Partner ___Both of us

Does either of you currently take prescribed psychiatric medication (anti-depressants, etc)?
If yes, who, what medication, and prescribed by whom?
_____
_____
_____

Is either of you currently suffering from general medical conditions, sleeping/eating problems, or depression/anxiety?
If, yes, who, and what symptoms are you experiencing?
_____
_____
_____
_____

Have either of you ever attempted suicide?
□ No
□ Yes
If yes, who, how many times, how, and when?_____
_____

Please share any relevant family history of mental health concerns:
_____
_____
_____

Signature	Date

Signature	Date