CLIENT INTAKE FORM: COUPLES' THERAPY

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Date ________________

GENERAL INFORMATION – please print
Referred by (if internet, which site/s?)

____

Client I
Last name _________________________________ First name_________________ MI ______
Birth date _____/______/_______ Age ________ Gender: • Female • Male
Address ____
(street) (city) (state & zip)

Cell phone ________________________________
Home phone ______________________________
Work phone _______________________________
Email address ____
Place of Employment__________________________ Length of Employment ______________
Type of work you do ____
Highest level of education completed: • High School • College • Graduate
• Professional training • Other ________________________
In case of emergency, contact:

____

Relationship ______________________________ Emergency phone_______________________

Client 2
Last name _________________________________ First name _____________________ MI ____
Birth date _____/______/_______ Age ________ Gender: • Female • Male
Address ____
(street) (city) (state & zip)

Cell phone ________________________________
Home phone ______________________________
Work phone _______________________________

Email address ____
Place of Employment__________________________ Length of Employment _____________
Type of work you do ____
Highest level of education completed: • High School • College • Graduate
• Professional training • Other ________________________
In case of emergency, contact:
____

Relationship _____________________________ Emergency phone_______________________

Relationship status: • engaged • married • partners • living together • separated

Length of time married/partnered (or length of relationship):
____

Others living in your home (Names/Relationship/Age):
______________________ __________________ ______________________
______________________ __________________ ______________________

Children not living in your home (Names/Ages):
______________________ __________________ ______________________
______________________ __________________ ______________________

COUNSELING CONCERNS
What is the major problem?
Client 1: ____
____

Client 2:____
____

How long have you had this problem?
Client 1: ____
____
Client 2: ____
____

When else have you had similar problems?
Client 1: ____
Client 2:____

Why are you seeking help now?
Client 1: ____

____

Client 2: ____
____

What would you like to see happen as a result of therapy?
Client 1: ____
Client 2: ____

MEDICAL AND PSYCHOLOGICAL HISTORY
Have you received psychotherapy or counseling in the past? • No • Yes
If so, when and with whom?
____
____

Client 1:
List any physical illnesses or symptoms:
____
____
Physician's and/or Psychiatrist's name(s) and phone number(s):
____
____
List current medications:
____
____

Client 2:
List any physical illnesses or symptoms:
____
____
Physician's/Psychiatrist's name(s) and phone number(s):
____
____
List current medications:
____
____

Have either of you received help for drug or alcohol abuse?
__No __Yes Who? __________________ When? ____________________
For what? ____
Where? ____

Have either of you been hospitalized for mental/emotional/psychiatric reasons?
__No __Yes Who?__________________ When? ____________________

For what? ____
Where?____

Family Mental Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, sister, grandmother, uncle, daughter, son, etc.).

Alcohol/Substance Abuse: □ No □ Yes ________________________________

Anxiety: □ No □ Yes ____

Depression:□ No □ Yes ____

Domestic Violence: □ No □ Yes ______________________________________

Eating Disorders: □ No □ Yes _______________________________________

Obesity:□ No □ Yes____

Obsessive Compulsive Behavior: □ No □ Yes _____________________________

OTHER
Please provide any other information you think will be necessary or helpful to achieve your therapy goals:
____
____
____