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NEW CLIENT INFORMATION

Couples Therapy Intake Form

To be completed by each partner separately. Please sign and date where indicated.

Name ____ DOB ___/___/____ Age ______

Race/Ethnicity _________________________________ Gender ________________________

Preferred Phone ____________________ □Cell □Home □Work Other: ________________

Email ____

Preferred Communication: □Cell □Home □Work □Email

Okay to leave a message on my: □ Home □Cell □ Work □ Other

Residential Address ____
City ________________________________ Zip ____________________

May I send mail to this address? Yes No

May I use your email to confirm appointments? Yes No

Employer ____
Type of Work ____

Relationship Status Single /Married /Partnership /Divorced /Separated /Widowed /Other

Emergency Contact___________________________________ Phone____________________

Relationship_________________________________

I. PROBLEM HISTORY & PRESENTING CONCERN

A. What prompted you to seek couples therapy at this time?

B. How are each of you impacted by the problem?

C. How does each partner contribute to the problem?

D. If the problem were resolved, how would you know? What would be different?

E. Please describe your strengths as a couple.

F. Please describe your challenges or struggles as a couple.

G. What have you already done to deal with difficulties?

H. Please describe your goals for therapy.

I. Please make at least one suggestion you could do personally to improve your relationship regardless of what your partner does. ____

____

J. Have you received couples therapy for any of the problems above before? ___ Yes ___ No

With whom, where, and for how long? ____

____

What was the outcome (check one)? □ Very successful □ Somewhat successful

□ Stayed the same □ Somewhat worse □ Much worse

II. RELATIONSHIP HISTORY

Length of relationship: ____

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)

Has 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

Do you perceive that either you or your partner has withdrawn from the relationship?

If yes, which of you has withdrawn? ____ Me ____ Partner ____ Both of us

How frequently have you had sexual relations during the last month? ________times

How enjoyable is your sexual relationship? (Circle one.)

1 2 3 4 5 6 7 8 9 10

(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one.)

1 2 3 4 5 6 7 8 9 10

(extremely unsatisfied) (extremely satisfied)

What is your current stress level (overall)? (Circle one.)

1	2	3	4	5	6	7	8	9	10
(no stress)									(high stress)

What is your current stress level (in the relationship)? (Circle one.)

1	2	3	4	5	6	7	8	9	10
(no stress)									(high stress)

Do you have any concerns about the way anger is handled in your relationship/family/living situation now? If yes, please explain. ____

____

____

Have you ever been or are you currently concerned about harming your partner? If yes, please explain:

____

____

____

____

Have you ever felt afraid of your partner? If yes, please explain:

____

____

____

____

III. PERSONAL HISTORY

A. Describe current living situation (household members, living situation, length of time in home):

____

____

____

____

____

____

B. Children

Name	Age	Gender	Location
______________________________	______	_________	________________

________________________________ ______ _________ _________________
________________________________ ______ _________ _________________
________________________________ ______ _________ _________________

C. Education

____
____
____

D. Employment

What kind of work have you done in the past?

____
____

What kind of work are you doing now?

____
____

Are you satisfied with your current work situation? _____ **Yes** _____ **No**
If no, briefly describe why:

____
____
____

Are there other sources of income (government benefits, retirement, trust fund, etc)?

____
____

IV. PHYSICAL & MENTAL HEALTH HISTORY

How would you describe the current state of your health? _____________________________

____
____
____

Do you have or have you ever had:

- Epilepsy
- Abdominal/digestive problems
- Diabetes
- Heart Problems
- Severe headaches
- High blood pressure
- Drug use
- Alcohol use
- Depression
- Lack of motivation
- Mental Illness
- Mood Swings
- Compulsions
- Concentration problems
- Aggressive behavior
- Crying
- Nervous tics
- Flashbacks
- Withdrawal/isolation
- Anxiety

- Surgery
- Breathing problems
- Under-eating
- Over-eating
- Vomiting
- Other eating problems
- Sexual problems
- Tobacco Use
- Sleep disturbances
- Temper outbursts
- Over work
- Chronic unemployment
- Phobic reactions
- Submissive behavior
- Impulsivity
- Obsessive thoughts
- Panic attacks
- Hypervigilance
- Over spending
- Loss of control
- Other, please explain:
  ____
  ____

Current Medications:
____
____
____
____

Have you ever had suicidal/homicidal thoughts? ____ Yes ____ No

If yes, please explain: ____
____

Have you ever had a suicide/homicide plan? ____ Yes ____ No

If yes, please explain: ____
____
____

Have you ever attempted suicide? ____ Yes ____ No

If yes, please give date(s) and circumstances: ____________________________________
____
____

Have you ever attempted to harm someone else? ____ Yes ____ No

If yes, please explain: ____
____
____

Are you thinking about suicide now? ____ Yes ____ No

If yes, please explain: ____
____
____

Are you thinking about hurting someone else now? ____ Yes ____ No

If yes, please explain: ____
____

V. Alcohol and Substance Use

Have you ever been treated for alcohol or drug dependence/abuse?
____Yes ____ No

Have you ever felt like you should cut down on alcohol or other drug use?
____Yes ____ No

Has a friend or relative ever discussed concerns about your drug use?
____Yes ____ No

Is there a history of problem with alcohol or drug use in your family?
____Yes ____ No

Have you received help for drug or alcohol dependency? ____ Yes ____ No

When? ________________________ Where? _________________________________

Check one: **Treatment was ____ helpful ____ not helpful. Please explain.**

____
____
____
____
____

VI. FAMILY HISTORY

Has any member of your family had any of the following? (please specify who)

- Drinking problem: ____
- Drug problem: ____
- Depression: ____
- Depression with highs and lows: ____
- Mental illness: ____
- Incarceration: ____
- Angry/abusive: ____
- Abused as a child: ____
- Suicidal/Suicide attempt: ____

Childhood
What role did (or do) you have in your family?

____
____
____

Please describe your developmental history. Did you struggle with meeting developmental timelines and/or a learning difficulty?

____
____
____

Do you remember seeing anything happen in your family that scared you? If so, explain.

____
____
____

How did (or do) your parents/caregivers get along? ____________________________________

____
____

Were you or any of your family members abused in any way or mistreated? _______________

____
____
____
____
____

VII. LEGAL ISSUES

EPOs, Criminal Charges, Incarceration, Custody and Divorce issues, CPS/APS – past and present

Please describe any legal issues with which you are involved currently or in the past.

____
____
____
____

VIII. SOCIAL SUPPORT

Describe your peer/social groups/friendships: ____

____
____
____
____
____

Have your parents, relatives or friends interfered with your job, school or relationship activities? If yes, briefly explain: ____

____
____
____

How comfortable do you feel in social settings?
____ Very relaxed ____ Relatively relaxed ____ Relatively uncomfortable
____ Very uncomfortable
Explain: ____
____
____
____

What kinds of activities do you engage in for fun? ____
____
____
____

IX. SPIRITUAL ASSESSMENT

What was your religion/faith experience as a child?
____
____
____

What is your religion/faith experience now?
____
____
____

How has your life experience led you to make sense of your world?
____
____
____
____

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.

By signing below, I confirm the information I provided on this document to be complete and truthful to the best of my knowledge.

Client Name (please print) ____

Signature of Client ____
(or authorized representative)

Date __________________________________