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COUPLES INTAKE FORM

Thank you for taking the time to complete this form. The information and history you provide to me will be helpful in planning services for you. Please answer each question carefully and ask about any question you don't understand. The information on this form is confidential and will not be released without your permission.

Today's Date: _____

How did you hear about me? Circle one:

☐ Family member ☐ Friend ☐ Internet ☐ Insurance ☐ Child Advocacy Center
☐ Other therapist ☐ Doctor ☐ Attorney ☐ Brochure ☐ Department of Human Services

Other: _____

Indentifying Information

Name: _____ Date of Birth: _____ Age: _____
Sex: ☐ M or ☐ F Race: _____ Religion: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Cell Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Work Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Occupation: _____ Place of Employment: _____
Relationship Status: _____

Family Composition

Name	Age	Date of Birth	Relationship	How well do they get along with other family members?

Medical History

Primary care provider: _____
Medications you are currently taking: _____
_____

Have you previously attended therapy? ☐ Y or ☐ N
Who did you see? _____
Reason you were seen in therapy: _____
Type of therapy you received: _____
Was the therapy helpful? Circle one: ☐ Helpful ☐ Somewhat helpful ☐ Not helpful

Have you experienced any of the following? Please circle and describe.
-chronic illness: _____
-surgeries: _____
-hospitalizations: _____
-high fevers: _____
-head injuries: _____
-seizures: _____
-eating problems: _____
-sleeping problems: _____
-problems with coordination: _____
-other: _____

Current Stressors

Please circle any of the stressors you have experienced over the last 12 months:

☐ Death of a parent	☐ Divorce	☐ Death of a spouse
☐ Remarriage	☐ Death of a family member	☐ Death of a child
☐ Personal injury or illness	☐ Job loss	☐ Sexual abuse (self)
☐ Sexual abuse (family member)	☐ Change in family member's health	☐ Birth of a child
☐ Alcohol/drug addiction in family	☐ Change in financial status	☐ Vacation
☐ Change in living condition	☐ Change in residence	☐ Change of job

Other: _____
_____
_____

Please describe why you are seeking therapy at this time: _____
_____
_____
_____

How long have you been experiencing these problems?_____
_____
_____

What have you tried to help yourself so far? _____
_____
_____
_____

Have you ever tried to hurt or kill yourself? ☐ Y or ☐ N

If yes, please describe: _____

_____

_____

If yes, when did this occur? _____

Now I would like to ask you about some other issues some people may have experienced in their past and current relationships. Please answer these questions as honestly as you can.

Do you feel safe in your current relationship? ☐ Yes ☐ No ☐ Sometimes

Do your arguments escalate out of control? ☐ Never ☐ Rarely ☐ Occasionally ☐ Very Often

Please place a check (√) next to any of the following statements that apply to you:
My partner …

☐ tries to control who I spend my time with

☐ does not believe me when I say where I've been

☐ pressures me to have sex when I don't want to

☐ talks me into doing things that make me feel bad

☐ prevents me from leaving the house when I want

☐ threatens me physically during arguments

☐ has pushed, slapped, hit, punched, or hurt me

☐ is suspicious that I am unfaithful

☐ keeps me from doing things I want to do

☐ verbally attacks my personality

☐ ridicules me

☐ threatens to hurt someone I care about

☐ damages things in our home

☐ humiliates me in front of others

Please use the following space if you'd like to add more detail: _____

_____

_____

_____

_____

Is there any other information that would be important for me to know? _____

_____

_____

_____

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____