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Couple Client Intake Information (please fill out together)

Today's Date: ___________ Referred by: ____________________________

Partner #1

Name Nickname

Address City, State, Zip

Cell Phone E-mail

Date of Birth Ethnic Background Gender

Occupation Employer/School Part or Full Time?

Current and Previous Mental Health Issues, Problems and/or Diagnoses

Hospitalizations? Current and Previous Suicide Attempts/Feelings?

Current or Previous Substance Use/Abuse?

Arrests, Legal Trouble or Domestic Violence?

(Optional): Name(s) of Current or Previous Therapist(s) and Dates Seen

Names and Dosages of Any Medication you are Taking

When was the Last Time Your Medications were Revisited/Checked?

Family Physician's Name Psychiatrist's Name

Current or Previous Physical Diseases or Limitations

Current Physical or Nutritional Concerns

Other Relevant Information You Would Like Me to Know About You

Partner #2

Name Nickname

Address City, State, Zip

Cell Phone E-mail

Date of Birth Ethnic Background Gender

Occupation Employer/School Part or Full Time?

Current and Previous Mental Health Issues, Problems and/or Diagnoses

Hospitalizations? Current and Previous Suicide Attempts/Feelings?

Current or Previous Substance Use/Abuse?

Arrests, Legal Trouble or Domestic Violence?

(Optional): Name(s) of Current or Previous Therapist(s) and Dates Seen

Names and Dosages of Any Medication you are Taking

When was the Last Time Your Medications were Revisited/Checked?

Family Physician's Name Psychiatrist's Name

Current or Previous Physical Diseases or Limitations

Current Physical or Nutritional Concerns

Other Relevant Information You Would Like Me to Know About You

Relationship

Marital/Commitment Status Length of Time Together Living Together?

If have Children, Please List their Names, Ages, and Primary Place of Residence

Any Other Persons or Relatives Living in your Home?

____

Name of Nearest, Close Relative, his/her Relationship to You, and Phone Number

Please check any of the following items that concern you:

_____ Self-esteem, self-confidence

_____ Anxiety, nervousness, fears

_____ Depression

_____ Sexual concerns

_____ Angry, hostile feelings

_____ Traumatic experiences

_____ Physical distress

_____ Eating or appetite problems

_____ Alcohol or drug problems

_____ Sleep problems

_____ Parent-child problems

_____ Spiritual/existential issues

_____ Family conflicts or pressures

_____ Friendship conflicts

_____ Relationship/marital concerns

_____ Shyness, being assertive

_____ Loneliness

_____ Procrastination or motivation

_____ Money/financial issues

_____ Suicidal feelings or behaviors

_____ Stress

_____ Self-control

_____ Health problems

_____ Work or career concerns

Please put a *second* check next to those that are of particular concern to you right now.

Please describe the main concerns that bring you here:

____

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Any additional information about your relationship?

____

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