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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:

Any additional information about your relationship?