Melissa Tolman
Psychotherapy Services

COUPLES INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here, is held to the same standards of confidentiality as our therapy.

Name(s): _____
Dates of Birth: _____
Phone number: _____
Emergency Contact (Name & Number): _____

TREATMENT HISTORY

Are you or your partner currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ( ) yes ( ) no

Have you or your partner had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)_____

(and why) _____

Are you or your partner currently taking prescribed psychiatric medication (antidepressants or others)? yes ( ) no

If yes, please list: _____ Prescribed by: _____ **HEALTH AND**

SOCIAL INFORMATION

Do you and your partner currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

_____

Are you or your partner currently on medication to manage a physical health concern? If yes, please list: _____
_____

Are you or your partner having any problems with your sleep habits? ( ) yes ( ) no

If yes, check and initial where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep

( ) Disturbing dreams ( ) other _____

Do you or your partner exercise? If so how many times per week? _____

Approximately how long each time? _____

Are you or your partner having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check and initial where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing

( ) Restricting

Have you or your partner experienced significant weight change in the last 2 months?

( ) no ( ) yes

Do you or your partner regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you or your partner have 4 or more drinks in a 24 hour period?

_____

How often do you or your partner engage recreational drug use? ( ) daily ( ) Weekly ( ) Monthly

Do you smoke cigarettes or use other tobacco products? ( ) No ( ) Yes

Have you or your partner had suicidal thoughts recently? ( ) No ( ) yES
( ) frequently ( ) sometimes ( ) rarely ( ) Never

Have you had them in the past?
( ) Yes ( ) No

Have you or your partner ever experienced any of the following? Check and initial where applicable

( )Extreme depressed mood Dramatic mood swings Rapid speech
( )Extreme anxiety

( )Panic attacks
( )Phobias
( )Sleep disturbances Hallucinations
( )Unexplained losses of time

( ) Unexplained memory lapses

( ) Alcohol/substance abuse Frequent body complaints Eating disorder

( ) Body image problems
( ) Repetitive thoughts (e.g. obsessions) Repetitive behaviors (e.g. frequent checking, hand washing)
( ) Homicidal thoughts
( ) Suicidal attempts

RELATIONSHIP QUESTIONS

How long have you been in this relationship? _____

Do you have children? If so how many, and how old are they? _____

On a scale of 1-10 (10 being the highest quality), how would you rate the satisfaction of your current relationship? _____

In the last year, have you experienced any significant life changes or stressors?

If yes, please explain: _____

_____

_____

What do you do when there is conflict between the two of you? What does your partner do?

_____

_____

What do you do when you are angry with your partner? What does your partner do when angry with you?

_____

_____

Do you or your partner use the following when arguing:

( ) Aggressive tone or words

( ) Physical touch or aggression

( ) Aggression towards objects

What strengths and weaknesses do you have in resolving conflict? What would you say are your partner's strengths and weaknesses in resolving conflict?

_____

_____

What have you already done to deal with the difficulties?

_____

_____

What are your hopes and Goals for counselling:

_____

_____

_____

_____