



Davina Counselling & Psychotherapy – Couple Counselling Intake Form

Supporting you with care, clarity, and respect

Client Details

Name: _____

Date of Birth: _____

Preferred Name: _____

Pronouns: He/Him/His She/Her/Hers They/Them/Theirs Prefer not to say

Contact Number: _____

Email: _____

Address: _____

Emergency Contact Name & Number: _____

GP Name & Clinic: _____

Mental Health History

Please share what feels comfortable. This helps us understand your journey and tailor support to your needs.

- Have you ever been diagnosed with a mental health condition?

Yes No Unsure If yes, what was the diagnosis?

- Have you ever received a Mental Health Care Plan from your GP?

Yes No Unsure

- Have you experienced any of the following? (tick all that apply)

Anxiety Depression Trauma/PTSD Eating concerns Mood changes Panic attacks Self-harm Suicidal thoughts

Other (please specify): _____

- Have you ever made a suicide attempt?

Yes No If yes, how long ago? _____

- Are you currently experiencing thoughts of suicide or self-harm?

- Yes No Prefer not to say

If yes, would you like support with this today? _____

- Have you had any experiences with addiction or compulsive behaviours?

Alcohol Drugs Gambling Gaming Social media Pornography

Sex

Other: _____

Would you like support with this? _____

- Do you currently use recreational drugs or alcohol?

Yes No If yes, please describe: _____

Couple Counselling

- What brings you to counselling now?

- What would you like to experience that feels different from your current situation?

- If you attended couples counselling for 6-12 sessions, how would you know it has been successful?

Personal Context & Strengths

- Are there any cultural, spiritual, or personal values you'd like me to be aware of?

- Have you experienced any significant life changes (e.g., grief, separation, relocation)?

- What are your strengths? What helps you feel safe or calm?

Any other information you would like us to know about you?
