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CLIENT INFORMATION INTAKE FORM FOR PARTNERSHIP COUNSELING
*****THIS INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL*****
(PLEASE PRINT CLEARLY)

Today's Date: ______________

Client Name: _________________________________ Birthdate________________

Age _________ Sex: ☐ MALE ☐ FEMALE

Level of Education: ☐ HS ☐ College ☐ Other _________________________________

Place/Type of Employment_________________ How long? _____ Full or Part time? __________

If unemployed, how long: _________________________________

What type of work do/did you do? _________________________________

Address____

Street___________________________ City________________ State_________ Zip________

Home Phone (___) ____________________Work Phone (___) ____________________

Partner Name: _________________________________ Birthdate________________

Age _________ Sex: ☐ MALE ☐ FEMALE

Level of Education: ☐ HS ☐ College ☐ Other _________________________________

Place/Type of Employment_________________ How long? _____ Full or Part time? __________

If unemployed, how long: _________________________________

What type of work do/did your partner do? _________________________________

Partner Address____

Street___________________________ City________________ State_________ Zip________

Home Phone (___) ____________________Work Phone (___) ____________________

Can a message be left with you and/or your partner? Yes No

Best Place to Leave a Message (___) ____________________

Who were you referred by?/How did you hear about me?

____

Relationship Status and For How Long?

Married ☐ __________ Living together ☐ __________ Divorced ☐ __________

Dating ☐ __________ Separated ☐ __________ Living apart ☐ __________

In process of divorce ☐ ___________ Engaged ☐ ___________

In Case of Emergency Notify: ___________________ Phone: _______________________

Relationship: ______________________

General Relationship History:

How long have you and your spouse/partner been together? ________________________________

If married, how many years? _________________________

How long did you date prior to marriage? ______________

How did you meet your spouse/partner? ____

____

____

How would you describe your relationship?

____

____

____

How would your spouse/partner describe your relationship?

____

____

____

Reason for seeking couples therapy at this time:

1. What is the problem(s) that led you to decide to come to couples therapy? How long has it been going on?

____

____

____

2. How is this relationship issue currently affecting other aspects of your life (i.e. work, family, parenting, etc.)?

____

____

____

3. What things have you tried to improve this issue? Did you experience any amount of success? Please explain.

____
____
____
____
____

4. What do you hope to accomplish through couples counseling?

____
____
____

5. How will you know that your relationship has improved?

____
____
____

6. What are your biggest strengths as a couple?

____
____
____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship:

1 2 3 4 5 6 7 8 9 10
(Extremely unhappy) (Extremely Happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does:

____

____

____

____

Have you ever received couples counseling related to any of the previously mentioned problems?

☐ YES ☐ NO

If yes:

Name of therapist/agency:

____

Length of treatment:

____

Outcome:

____

Have either you or your partner/spouse been, or currently are, in individual counseling?

☐ YES ☐ NO

If yes, please give a summary of concerns addressed:

____

____

____

Do either of you have any problems with Alcohol? ☐ Drugs? ☐ Nicotine? ☐

Do you or your partner have current thoughts of harming yourself, each other or someone else?

☐ YES ☐ NO

If so, is there a plan?

☐ YES ☐ NO

Do you or your partner have resources to act out harming yourself, each other or someone else? YES

☐ YES ☐ NO

Have you or your partner ever had thoughts about suicide ☐ YES ☐ NO

Have you or your partner ever attempted suicide? ☐ YES ☐ NO

If yes, how many times? ___________

Please check off the problems that you and your partner are having in your life right now or previously: (ME for yourself, P for partner, B for both)

- ☐ Depression
- ☐ Anxiety
- ☐ Stress
- ☐ ADHD
- ☐ Post-Traumatic Stress/PTSD
- ☐ Headaches
- ☐ Nervousness
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shyness
- ☐ Stomach Trouble
- ☐ Inability to Relax
- ☐ Unhappiness
- ☐ Fatigue
- ☐ Legal Matters and Issues
- ☐ Problems with Self Control
- ☐ Poor Appetite
- ☐ Concentration Problems
- ☐ Bad Temper
- ☐ Ambition
- ☐ Health Problems
- ☐ Death of a Spouse/Partner
- ☐ Major Injury
- ☐ Bad Break Up
- ☐ Anger
- ☐ Poor Memory
- ☐ Decision Making
- ☐ Insomnia
- ☐ Nightmares
- ☐ Separation
- ☐ Poor Energy
- ☐ Feeling Inferior
- ☐ Illicit Drug Use
- ☐ Alcohol Use Problems
- ☐ Cigarette Smoking
- ☐ Loneliness
- ☐ Marriage/Relationship Issues
- ☐ Allergies
- ☐ Suicidal
- ☐ Sexual Problems
- ☐ Work
- ☐ Eating Issues
- ☐ Problems with Home
- ☐ Problems with Friends
- ☐ Traumatic Brain Injury
- ☐ Death of a Family Member
- ☐ Financial Issues
- ☐ Job Dissatisfaction/Bullying at Work
- ☐ Aging and Mortality
- ☐ Financial Issues
- ☐ My Appearance/Looks
- ☐ My Future/Ambitions
- ☐ History of Sexual Abuse
- ☐ History of Physical Abuse
- ☐ History of Emotional Abuse
- ☐ History of Trauma
- ☐ Career Choices
- ☐ Weight/Body Image Issues
- ☐ Mood Swings
- ☐ Fears
- ☐ Poor Self-Esteem
- ☐ Worries
- ☐ Sexual Orientation
- ☐ Athletic Performance
- ☐ Public Speaking Issues
- ☐ Motivation Problems
- ☐ Divorce
- ☐ My Thoughts
- ☐ Autism Spectrum Issues
- ☐ Major Illness
- ☐ Relocation to/from Elsewhere
- ☐ Job Loss

Current or Past Family Stressors

Is there a history of addiction in your family? Please describe:

____

____

____

____

Is there a history of abuse or violence in your family? Please describe:

____

____

____

____

Additional Information

Is there any additional information that you feel is important to provide at this time?

____

____

____

____

I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided. I hereby affirm that I I authorize services under the terms of this agreement.

Signature: ____ Date: _______________