PEACE, LOVE & COUNSELING by Fran
Individuals, Couples, Families & Systems
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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 checking 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 ☐ 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)

PROBLEM	ME	PARTNER	BOTH
Depression	☐	☐	☐
Anger	☐	☐	☐
Aging and Mortality	☐	☐	☐
Anxiety	☐	☐	☐
Poor Memory	☐	☐	☐
Financial Issues	☐	☐	☐
Stress	☐	☐	☐
Decision Making	☐	☐	☐
My Appearance/Looks	☐	☐	☐
ADHD	☐	☐	☐
Insomnia	☐	☐	☐
My Future/Ambitions	☐	☐	☐
Post-Traumatic Stress/PTSD	☐	☐	☐
Nightmares	☐	☐	☐
History of Sexual Abuse	☐	☐	☐
Headaches	☐	☐	☐
Separation	☐	☐	☐
History of Physical Abuse	☐	☐	☐
Nervousness	☐	☐	☐
Poor Energy	☐	☐	☐
History of Emotional Abuse	☐	☐	☐
Dizziness	☐	☐	☐
Feeling Inferior	☐	☐	☐
History of Trauma	☐	☐	☐
Fainting Spells	☐	☐	☐
Illicit Drug Use	☐	☐	☐
Career Choices	☐	☐	☐
Shyness	☐	☐	☐
Alcohol Use Problems	☐	☐	☐
Weight/Body Image Issues	☐	☐	☐
Stomach Trouble	☐	☐	☐
Cigarette Smoking	☐	☐	☐
Mood Swings	☐	☐	☐
Inability to Relax	☐	☐	☐
Loneliness	☐	☐	☐
Fears	☐	☐	☐

Unhappiness	☐	☐	☐
Marriage/Relationship Issues	☐	☐	☐
Poor Self-Esteem	☐	☐	☐
Fatigue	☐	☐	☐
Allergies	☐	☐	☐
Worries	☐	☐	☐
Legal Matters and Issues	☐	☐	☐
Suicidal	☐	☐	☐
Sexual Orientation	☐	☐	☐
Problems with Self Control	☐	☐	☐
Sexual Problems	☐	☐	☐
Athletic Performance	☐	☐	☐
Poor Appetite	☐	☐	☐
Work	☐	☐	☐
Public Speaking Issues	☐	☐	☐
Concentration Problems	☐	☐	☐
Eating Issues	☐	☐	☐
Motivation Problems	☐	☐	☐
Bad Temper	☐	☐	☐
Problems with Home	☐	☐	☐
Divorce	☐	☐	☐
Ambition	☐	☐	☐
Problems with Friends	☐	☐	☐
My Thoughts	☐	☐	☐
Health Problems	☐	☐	☐
Traumatic Brain Injury	☐	☐	☐
Autism Spectrum Issues	☐	☐	☐
Death of a Spouse/Partner	☐	☐	☐
Death of a Family Member	☐	☐	☐
Major Illness	☐	☐	☐
Major Injury	☐	☐	☐
Financial Issues	☐	☐	☐
Relocation to/from Elsewhere	☐	☐	☐
Bad Break Up	☐	☐	☐
Job Dissatisfaction/Bullying at Work	☐	☐	☐
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: _____