New Client Intake Form for Couples

Identifying Information

Name _____ Age _____ Birth Date _____
Address _____ City _____ State _____ Zip Code _____
Name you prefer to be called _____
Gender _____ Race_____
Address _____
Home Phone _____ OK to leave message? Y/N
Cell Phone _____ OK to leave message? Y/N OK to text? Y/N
Work Phone _____ OK to leave message? Y/N
Email _____
How do you prefer that I contact you? _____
Emergency Contact _____Relation _____ Phone_____
Marital Status: Single/Married/Separated/Divorced/Widowed/Dating/Other: _____
Are you currently living together? Y/N Length of time in current relationship: _____
How did you hear about this practice? _____

Couples History

1. What is/are the main problem(s) or issue(s) that has/have motivated you to seek counseling at this time?
   _____
   _____
   _____
   _____
2. What have you already done to address the problems(s)/issue(s)?
   _____
   _____
3. What are your goals for counseling? _____
   _____

Strengths and Identified Opportunities for Growth

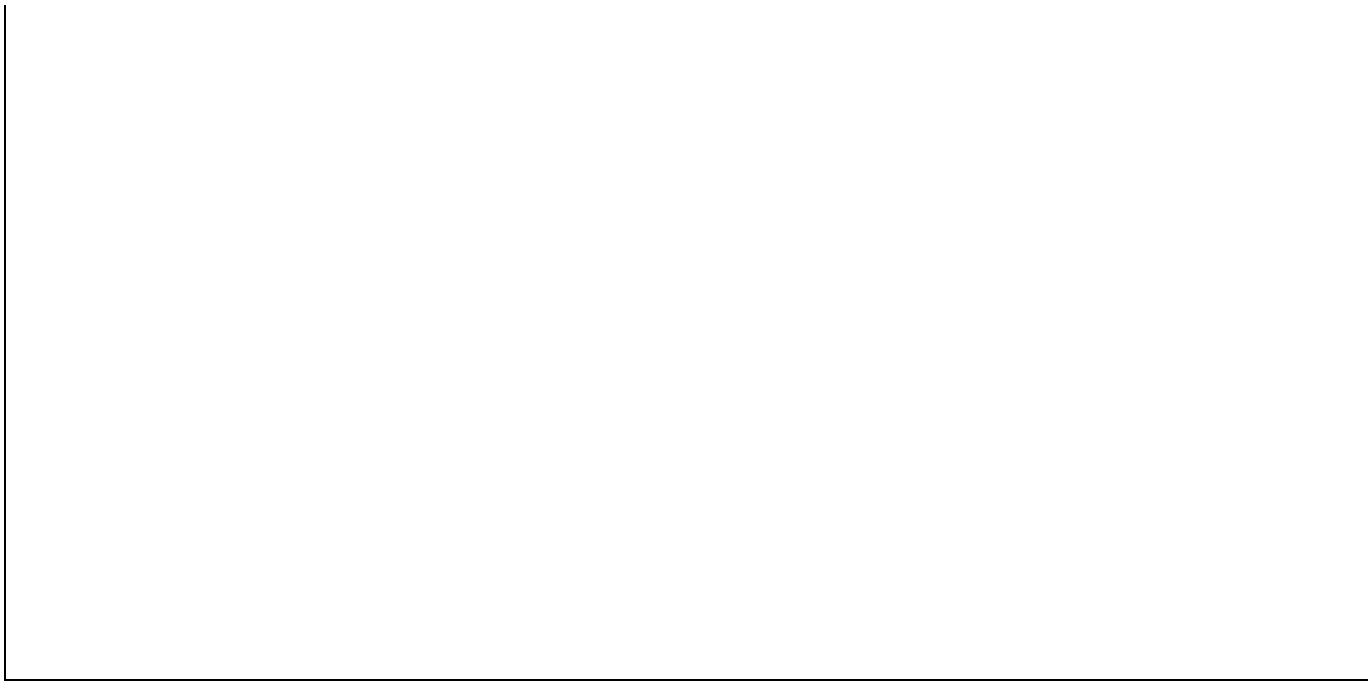
4. What are your top 3 strengths as a couple?
   _____
   _____
   _____
5. Describe 3 areas that you could grow in as a couple.
   _____
   _____
   _____
6. Please rate your level of relationship happiness by circling the number that corresponds with your current feelings about the relationship. (Circle one.)
   (extremely unhappy) 1 2 3 4 5 6 7 8 9 10 (extremely happy)
7. Have either you or your partner struck, physically restrained, used violence, or injured the other person?
   ___Yes ___No If yes for either, who, how often, and what happened?
   _____
   _____

8. Have either of you threatened to separate or divorce (if married) as a result of the current relationship problems?
   ___Yes ___No If yes, who? _____ Me _____Partner _____Both of us
9. If married, have either you or your partner consulted with a lawyer about divorce?
   ___Yes ___No If yes, who? _____Me _____Partner _____Both of us
10. Do you perceive that either you or your partner has withdrawn from the relationship? ___Yes ___No
    If yes, who? ___Me ___Partner ___Both of us
11. How frequently have you had sexual relations during the last month? _____ Times
12. How enjoyable is your sexual relationship? (Circle one.)
    (extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)
13. How satisfied are you with the frequency of your sexual relations?
    (extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)
14. Randy order the top 3 concerns you have in your relationship (1 being the most problematic)

1. _____
2. _____
3. _____

15. Please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note pivotal/significant events in your relationship (e.g. one of your moved out, one of you cheated).

Complete Satisfaction



No Satisfaction

Relationship Over Time

When you met/began dating Current

Family History

Please list family members from your family of origin, including their ages, marital history, and employment status. Then describe what your relationship was/is like with each person) close, distant, strained, etc.). If any have died, please record the year of death, the person's age, and your age at the time of that death.

1. Do you have any children? ____Yes ____No If so, please list their names, ages, and describe your relationship with each.
   _____
   _____
   _____
   _____
2. Identify any mental health (such as depression, anxiety, post-traumatic stress, suicide attempts, etc.) or substance use disorder (such as alcohol, marijuana, cocaine/crack, methamphetamines, inhalants, hallucinogens, heroin/opiates, prescription drugs, cigarettes/cigars, caffeine, other) diagnoses in your family. Place a * by any mental health or substance use disorders that are current. Include also any in-patient care for substance abuse or mental health.
   Mother _____
   Father _____
   Stepmother _____
   Stepfather _____
   Siblings _____
   Grandparents _____
   You _____
   Your partner _____
   Other _____

Social History:

Please check your current status. ____ Employed ____Student _____Unemployed _____Disabled _____Retired

1. If employed and/or a student, where are you working and/or studying?
   _____
2. What is/was your position/occupation? _____
3. Level of education achieved (Check the highest one.)
   ( ) Elementary School
   ( ) Middle School
   ( ) High School Diploma
   ( ) Associate Diploma – area of study: _____
   ( ) Bachelor's Degree – area of study: _____
   ( ) Master's Degree – area of study: _____
   ( ) Doctorate Degree – area of study: _____
   ( ) Other qualification – area of study: _____

4. Have you experienced or witnessed any of the following types of abuse: ___Yes ___No
5. If yes, please circle which types and describe what happened briefly.
   Physical Abuse _____
   Emotional Abuse _____
   Financial Abuse _____
   Sexual Abuse _____
   Spiritual Abuse _____
   Neglect _____
   Intimate Partner Violence _____
   Other _____

Health Information

1. Describe your health. _____
2. List significant illnesses or injuries._____
   _____
3. Primary Care Physician: _____ Date of last medical exam: _____
4. Result of last medical exam: _____
5. List current medication and dosages. _____
   _____
   _____
   _____
6. Have you ever seen a psychiatrist, psychologist, mental health practitioner or pastor for assistance? Y/N
   Describe your past experiences with any of these individuals, including dates and types of treatment.
   _____
   _____
   _____
7. Are you now having suicidal thoughts or have you ever? ___ Now ___ In the past ___Never
   If you have ever had suicidal thoughts, please describe for how long and what you have done to get help.
   _____
8. Are you now or have you ever engaged in self-harming behaviors (cutting, hitting, burning)? ___ Yes ___ No
   If yes, what type and for how long? _____

Current Problems

Below is a list of problems and concerns that people sometimes have. Please identify any problem that has bothered you in the past two weeks with a number indicating the degree of severity (1=mild, 2=moderate, 3=severe).

____Trouble remembering things
____Feeling easily annoyed or irritated
____Pains in the heart or chest
____Feeling afraid
____Poor appetite
____Temper outbursts you could not control
____Feeling blocked in getting things done
____Feeling lonely
____Feeling blue
____Feeling no interest in things
____Feeling that people are unfriendly or dislike you
____Thoughts of ending your life
____Feeling that other watch or talk about you
____Trouble sleeping
____Difficulty making decisions
____Eating issues
____Legal issues
____Parenting concerns
____Homicidal thoughts
____Time management
____Poor social relationships
____Gambling
____Internet abuse
____Gender Identity
____Self-injury (cutting, hitting, burning)
____Feelings of anger
____Financial issues
____Conflict over control issues
____Marital issues
____Feeling hopeless about the future
____Trouble concentrating
____Feeling tense or keyed up
____Spells of terror or panic
____Feeling so restless you could not sit still
____Feelings of worthlessness
____Feelings of guilt
____Feelings of failure
____Feeling that something is wrong with your mind
____Unusual thoughts
____Physical health issues
____Relationship problems
____Feelings of insecurity
____Family conflicts
____Alcohol and/or drug use
____Grief
____Body image concerns
____Stress
____Physical abuse
____Spiritual concerns or confusion
____Forgiveness
____Suicidal thoughts
____Pornography
____Post Abortion
____Boundaries
____Sexual Abuse/Trauma
____Divorce Issues
____Conflict with authority
____Sexual issues

Spiritual Life

1. Do you happen to attend church regularly at this time? Y/N
   If so, where? _____
2. How does spirituality affect your life?
   _____
   _____
   _____

Please return completed forms at the time of appointment.