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COUPLES INTAKE FORM

Thank you for taking the time to complete this form. The information and history you provide to me will be helpful in planning services for you. Please answer each question carefully and ask about any question you don't understand. The information on this form is confidential and will not be released without your permission.

Today's Date: _____

How did you hear about me? Circle one:

Family member	Friend	Internet	Insurance	Child Advocacy Center
Other therapist	Doctor	Attorney	Brochure	Department of Human Services

Other: _____

Indentifying Information

Name: _____ Date of Birth: _____ Age: _____
Sex: M or F Race: _____ Religion: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Okay to leave a message? Y or N
Cell Phone Number: _____ Okay to leave a message? Y or N
Work Phone Number: _____ Okay to leave a message? Y or N
Occupation: _____ Place of Employment: _____
Relationship Status: _____

Family Composition

Name	Age	Date of Birth	Relationship	How well do they get along with other family members?

Medical History

Primary care provider: _____
Medications you are currently taking: _____
_____

Have you previously attended therapy? Y or N
Who did you see? _____
Reason you were seen in therapy: _____
Type of therapy you received: _____
Was the therapy helpful? Circle one: Helpful Somewhat helpful Not helpful

Have you experienced any of the following? Please circle and describe.
-chronic illness: _____
-surgeries: _____
-hospitalizations: _____
-high fevers: _____
-head injuries: _____
-seizures: _____
-eating problems: _____
-sleeping problems: _____
-problems with coordination: _____
-other: _____

Current Stressors

Please circle any of the stressors you have experienced over the last 12 months:

Death of a parent	Divorce	Death of a spouse
Remarriage	Death of a family member	Death of a child
Personal injury or illness	Job loss	Sexual abuse (self)
Sexual abuse (family member)	Change in family member's health	Birth of a child
Alcohol/drug addiction in family	Change in financial status	Vacation
Change in living condition	Change in residence	Change of job

Other: _____
_____
_____

Please describe why you are seeking therapy at this time: _____
_____
_____
_____

How long have you been experiencing these problems?_____
_____
_____

What have you tried to help yourself so far? _____
_____
_____
_____

Have you ever tried to hurt or kill yourself? Y or N

If yes, please describe: _____

_____

_____

If yes, when did this occur? _____

Now I would like to ask you about some other issues some people may have experienced in their past and current relationships. Please answer these questions as honestly as you can.

Do you feel safe in your current relationship? Yes No Sometimes

Do your arguments escalate out of control? Never Rarely Occasionally Very Often

Please place a check (√) next to any of the following statements that apply to you:
My partner …

___ tries to control who I spend my time with

___ does not believe me when I say where I've been

___ pressures me to have sex when I don't want to

___ talks me into doing things that make me feel bad

___ prevents me from leaving the house when I want

___ threatens me physically during arguments

___ has pushed, slapped, hit, punched, or hurt me

___ is suspicious that I am unfaithful

___ keeps me from doing things I want to do

___ verbally attacks my personality

___ ridicules me

___ threatens to hurt someone I care about

___ damages things in our home

___ humiliates me in front of others

Please use the following space if you'd like to add more detail: _____

_____

_____

_____

_____

Is there any other information that would be important for me to know? _____

_____

_____

_____

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____