

Couple/Family Intake Form

Name/Adult #1 _____ Date of Birth/Age: _____

Address: _____

Telephone/E-Mail: Please indicate if it is O.K. to leave/send messages.

Home: _____ Yes No Cell: _____ Yes No

Work: _____ Yes No E-Mail: _____ Yes No

Occupation _____

Education: Last Grade Completed: _____ Vocational Training _____

Are you presently under a physicians care? Yes No If yes, for what? _____

List any medications and amount. _____

Name/Phone/Address of Physician _____

Have you or anyone in your family been hospitalized for a psychiatric illness Yes No

If yes, please explain:

Name/Adult #2 _____ Date of Birth/Age: _____

Address (if different than Adult #1) _____

Telephone/E-mail: Please indicate if it is O.K. to leave/send messages:

Home: _____ Yes No Cell: _____ Yes No

Work: _____ Yes No E-Mail: _____ Yes No

Occupation _____

Education: Last Grade Completed: _____ Vocational Training _____

Are you presently under a physicians care? Yes No If yes, for what? _____

List any medications and amount. _____

Name/Phone/Address of Physician _____

Have you or anyone in your family been hospitalized for a psychiatric illness Yes No

If yes, please explain:

Are there any other persons living in your home? Yes No

If yes, what is their name and relationship to you? _____

Current Relationship Status (check all that apply)

Married Living Together Living Apart Separated Divorced Widowed

How long have you been married, divorced, etc.? _____

Has either of you or your spouse/partner been married before? Yes No

If yes, whom and for how long? _____

In the case of divorce or separation from previous partners what was the reason?

Children/Siblings (include biological, adopted, foster, step, etc.):

<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Type (bio,step)</u>	<u>Living with you?</u>
_____	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Has anyone in your family ever participated in counseling? If yes, who and what were the issues.

What do you as a couple and/or family hope to accomplish through counseling?

What have you already done to deal with the difficulties?

What as a couple/family are your biggest strengths? What do you do for fun and/or stress relief?

Does anyone in your family consume alcohol and/or substances? If yes, whom and how much?

Name/Adult #1 _____ Please check all that apply.

	PAST	PRESENT
Problem/Difficulty		
Physical Problems		
Substance Use/Abuse/Addictions		
Sexual Abuse		
Thoughts/Behaviors of harming self or others		
Irregular Eating Habits		
Sleep Problems		
Performance at School		
Performance at Work		
Making Friends		
Understanding Others		
Shyness		
Feeling Victimized		
Feeling Rejected		
Unable to have a good time		
Feel cut off from others		
Communication Problems		
Sexual Problems		
Financial Problems		
Specific Fears:		
Can't stop thinking about:		
Feeling Depressed		
Feeling Inferior		
Emotionally Numb		
Lack of Confidence		
Excessive Worry		
Can't Make Decisions		
Don't like Week-Ends or Vacations		
Forgetfulness		
Lack of Goals		
Unable to Cope with Day to Day life		
Afraid of being on My Own		
Suicidal Thoughts/Behaviors		
Feeling Tense/Anxious		
Feeling Angry		
Can't sit still		
Over-ambitious		
Seeing or hearing things		
Nightmares		

Name/Adult #2 _____ Please check all that apply.

	PAST	PRESENT
Problem/Difficulty		
Physical Problems		
Substance Use/Abuse/Addictions		
Sexual Abuse		
Thoughts/Behaviors of harming self or others		
Irregular Eating Habits		
Sleep Problems		
Performance at School		
Performance at Work		
Making Friends		
Understanding Others		
Shyness		
Feeling Victimized		
Feeling Rejected		
Unable to have a good time		
Feel cut off from others		
Communication Problems		
Sexual Problems		
Financial Problems		
Specific Fears:		
Can't stop thinking about:		
Feeling Depressed		
Feeling Inferior		
Emotionally Numb		
Lack of Confidence		
Excessive Worry		
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Feeling Angry		
Can't sit still		
Over-ambitious		
Seeing or hearing things		
Nightmares		

Were you referred? Yes No By Whom? _____

If you were not referred how did you find this counseling service? _____

Person to contact in case of emergency:

Name: _____

Address: _____

Phone: _____

IT IS CUSTOMARY TO PAY YOUR THERAPIST AFTER EACH SESSION.

A Counseling Session is normally **50** minutes. If longer sessions are desired please discuss this with your therapist. Fees increase with longer sessions.

A 24-HOUR CANCELLATION NOTICE IS APPRECIATED, OTHERWISE A FEE WILL BE CHARGED.

Form completed by:

Signature/Adult #1 _____ Date _____

Printed signature _____

Signature Adult #2 _____ Date _____

Printed signature _____