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CONFIDENTIAL COUPLES THERAPY INTAKE FORM

Client Name: _____ Age:_____ Birthdate:_____
Phone #: _____ Email Address: _____
Ok to text appointment reminders? Y/N Email ok for appointment scheduling? Y/N
Home address: _____
Occupation: _____
Spouse/Partner name: _____

CHILDREN

Name	Age	Dates of any prior marriages & divorces
_____		_____
_____		_____
_____		

CURRENT RELATIONSHIP CIRCUMSTANCES

Total years together _____ Married? Yes/No Years Married _____ Marriage date _____
Pregnancy before marriage? Yes/No

Why are you seeking therapy at this time?

_____
_____
_____
_____
_____

CIRCLE THE ITEMS THAT YOU HAVE EXPERIENCED OVER THE PAST MONTH OR ARE EXPERIENCING NOW

Headaches
Itching
Faintness
Hot flashes
Dry mouth
Tightness in jaw
Muscle spasms
Overeating
Cold hands/feet
Loss of sexual desire
Twitches, tics, spasm
Lump in throat
Stuttering
Grinding of teeth
Loneliness
Suicidal thoughts
Violent thoughts
Violent behavior
Self-Mutilation
Suicidal attempts
Sweaty palms

Weakness in parts of body	Lower back pain	Chest pain
Heavy feeling in arms/legs	Feeling bored	Allergies
Low motivation	Repeated house checking	Emotional outbursts
Tense/nervous	Nausea	Fatigue
Waking early	Difficulty falling asleep	Bad dreams
Breathlessness	Mind going blank	Fear of places/events
Difficulty w/ decisions	Feeling fearful	Trouble remembering
Feeling inferior to others	Ruminating thoughts	Difficulty concentrating
Thoughts of ending your life	Poor appetite	Loss of interest in things
Crying easily	Trouble waking up	Sexual functioning issues

Factors contributing to the current marital difficulties. Check all that apply.

Recently had difficulty communicating _____
Always had difficulty communicating _____
Differences in interests _____
Differences in education level _____
Differences in ethnic or racial background _____
Differences in expectations of marriage _____
Differences in expectations about family _____
Differences in parenting approach _____
Changes in lifestyle, values _____
Lack love for one another _____
Lack of respect for one another _____
Verbal abuse _____
Bored _____
Sexual difficulties _____
In love with another person _____
Unfaithful/infidelity _____
Abuse or neglect of children _____
Job problems _____
Suspiciousness, jealousy _____
Neglect of home _____
Trouble with in-laws _____
Drinking _____
Excess pornography viewing _____
Drug use _____
Sexual abuse _____
Other (explain)_____

On a scale of 1-10 rate the level of conflict between you and your spouse.

We get along very well_____ we have constant conflict
1 10

On a scale of 1 to 10 rate how well you and your spouse communicate

We communicate very well_____ we have great trouble
1 10

Check major life events and/or changes occurring within the last 12 months.

Started school or training program _____
Changed job _____
Lost job _____
Moved residence _____
Financial troubles _____
Increase in financial responsibilities _____
Legal problems _____
Arrested and/or jailed _____
Separation or divorce of friend or relative _____
Health problems (self, spouse, children) _____
Drinking or drug problems _____
Began treatment for substance abuse problems _____
Began individual therapy _____
Began new medications _____
Significant weight gain/loss _____
Nanny or aging parent joined household _____
Nanny or aging parent left household _____
Death of pet _____
Pregnancy _____
Miscarriage _____
Abortion _____
Fertility problems _____
Troubled child _____
Onset of menopause _____
Mid-life crisis _____
Victim of crime _____
Auto accident _____
Empty nest _____

What do you hope to accomplish in couples' therapy? What are your goals?

_____

_____

_____

Current Sources of Emotional Support:

Friends _____
Family _____
Neighbors _____
Co-workers _____
Religion or spiritual practice _____
Therapist/counselor _____

Are you currently employed? **Yes / No**

How satisfied are you with your current job/work situation?

Very satisfied_____ Moderately satisfied _____
Moderately unhappy _____ Extremely unhappy _____

Have you ever had significant health problems or mental illness affecting you for an extended period of time? Please explain.

_____

_____

_____

At present your health is generally:

Good _____Fair_____ Poor _____

Do you have any history of the following? Circle

Heart Disease	**Irritable bowel syndrome**	**Chronic Pain**	**Eating Disorder**
Blood Pressure	**Thyroid Problems**	**Concussion**	**Arthritis**
Migraines	**Arteriosclerosis**	**Diabetes**	**Stroke**
Alcoholism	**Drug Addiction**	**Hepatitis**	**Cancer**

What prescription medication do you take currently?

_____

_____

_____

Recreational drug use presently? Yes/ No In the past? Yes/No

If you drink alcohol, how much and how often? _____

Are you concerned about the drug/alcohol use of your partner?
Yes/No If yes, please explain.

_____

_____

_____

Are you currently in couples, family or individual counseling or have you been in the past?
Yes/No

Has your current or previous therapy been helpful? If so, in what way, or why not?

_____

_____

Anniversary dates of any significant losses (name and relationship to you)

_____

_____

History or trauma or abuse? Yes/No If yes, please explain.

_____

_____

_____

Have you ever had suicidal thoughts? Yes/No Have you ever made a suicide attempt? Yes/No

Has anyone in your family committed suicide? Yes/No If yes, what is the relationship to you?

_____

How stressful is your life right now? Not ___ Mildly ___ Moderately ___ Extremely ___

How often do you exercise? _____ What type of exercise? _____

Are you going through menopause? Yes/No Are you post menopausal? Yes/No If yes are you taking hormone replacement? Yes/No

How were you referred to me?

Google Search _____ Therapist referral _____ If so please provide name.

Beyond the information provided here, what else do you feel is important for me to know about you and your current situation?

_____

_____

_____

_____

Your Signature

_____ **Date:** _____