

INTAKE FORM for COUPLE'S COUNSELLING

CONTACT INFORMATION

1. _____ 2. _____
Name Date of Birth Name Date of Birth

Address _____

Phone Number _____ Is it okay to leave messages?
(best number to reach you at) Yes No

Email address _____
(if you are comfortable with this form of contact)

Emergency Contact _____
(someone NOT attending sessions) Name Phone Number

RELATIONSHIP INFORMATION

How many years together? _____ If applicable, Date moved in together _____ If married, Date of union _____

For each partner, indicate **previous relationship status**

1. _____ 2. _____
Name Name

Divorced Widowed Separated Divorced Widowed Separated

This is my 1st marriage/partnership This is my 1st marriage/partnership
 2nd 2nd
 3rd 3rd
 4th 4th

Names and ages of **children**

Name	Age	Name	Age
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

HEALTH CONCERNS

Please indicate the health concerns in your family.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> AD/HD | <input type="checkbox"/> Chronic Pain or Fatigue | <input type="checkbox"/> Hyper/Hypo Glycemia | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyper/Hypo Thyroid | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach or Digestive Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Borderline Disorder | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Panic Attacks | Other: _____ |

HEALTH CONCERNS CONT...

Please indicate if either of you are experiencing any of the following:

	Name		Name
Feelings of sadness, crying, being down	_____	Concerns about sexuality	_____
Racing thoughts	_____	Use of alcohol or drugs	_____
Unwanted or intrusive thoughts	_____	Doing things over and over	_____
Times when I can't control what I do	_____	Seeing or hearing things that other's don't	_____
Sleep problems	_____	Feeling anxious or nervous	_____
Feeling worthless	_____	Pain or health concerns	_____
Difficulty controlling my temper	_____	Spiritual concerns	_____
Eating problems	_____	Some things are too painful to talk about	_____

Have one or both of you been in counselling before? Yes No If so, when _____

Briefly describe the reason for seeking counselling at that time.

OVERALL COUPLE HEALTH OR CONNECTEDNESS

In general, our relationship is 1 2 3 4 5 6 7 8 9 10
poor excellent

Please check if the relationship is dealing with Abuse Addiction(s) Affair(s) Incest Financial strain

Comments:

Please check which statement best applies to your relationship:

- We are a well-adjusted/well-connected couple. We do alright but have some areas of concern.
 We're functioning but just barely. We're a complete mess.

Principle concern/reason for seeking couple's counselling at this time:

Thank you for taking the time to complete this form.
Feel free to call me with any questions or concerns, or mention them when we meet.