



COUPLE'S INTAKE FORM FOR HER

CONTACT INFORMATION FOR HER

Her Name _____ Date _____

Date of Birth _____ SS# _____

Telephone Numbers:

Home: _____ Work: _____ Cell: _____

Address: _____

Email: _____ Referred by: _____

Emergency Contact Information:

Name _____ Relationship _____

Telephone Numbers:

Home: _____ Work: _____ Cell: _____

HER RELATIONSHIP INFORMATION

Employment _____

Legal Status: (Please Circle) Single Married Separated Divorced Widowed

Spouse Name _____ Employment _____ Phone Number _____

Describe your present living arrangement. Please list everyone with whom you live.

Name	Age	Gender	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list your marriage(s) or other important significant other relationships

Name	Year Begun - Year Ended	Married?	Children from this relationship and ages
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HER HEALTH BACKGROUND

Have you seen a counselor before? ___Yes ___No

If yes, when? _____ For how long? _____

With whom? _____ What was the primary issue? _____

Have you ever been hospitalized for emotional problems or drug/alcohol treatment? ___Yes ___No

If yes, when? _____ For how long? _____

Where? _____ What was the outcome? _____

Primary Care Physician _____ Phone _____

Do you have any chronic medical concerns? ___Yes ___No

If yes, please list: _____

List all allergies, serious illnesses, injuries, surgeries, hospitalizations and any other medical conditions you have had:

List all medications or drugs (legal or illegal) you are currently taking or have taken in the last year:

Additional Information:

HER CONCERNS

What are the main reasons you are seeking couples counseling at this time? _____

What stressful events have recently occurred? _____

Please circle all items below that currently apply, and feel free to add any notes or details next to the word.
 You may add any other concerns at the bottom of the page.

- | | | | | |
|-------------------------|---------------------|------------------------------------|------------------------------|-----------------------------|
| Abuse (Past or Present) | Divorce | Inferiority feelings | Oversensitivity | Shyness |
| Alcohol use | Dizziness | Inhibitions | Panic/anxiety attacks | Sleep problems |
| Anger | Eating Issues | Internet Pornography | Parenting | Startle easily |
| Anxiety | Education | Irritability | Perfectionism | Stomach problems |
| Attention Problems | Employment Issues | Legal matters | Pessimism | Stress |
| Being a parent | Emptiness | Loneliness | Phobias | Suicidal thoughts/ feelings |
| Binging/ Purging | Failure | Loss of Control | Physical problems | Suspiciousness |
| Career Choices | Fainting spells | Losses | Problems sleeping | Temper |
| Change in appetite | Fatigue | Low energy | Relationship problems | Temper problems |
| Chest pain | Fears | Low frustration tolerance | Recurring/Unwanted thoughts | Tension/Stress |
| Childhood issues | Feeling inferior | Making decisions | Religious/Spiritual concerns | Time Management |
| Children | Financial problems | Marital coldness | Restricting food intake | Thoughts of hurting others |
| Choices I have made | Friendship problems | Marital conflict | Ring in ears | Threats of violence |
| Codependence | Gambling | Marital infidelity/affairs | Sadness | Tiredness |
| Concentrating | Grieving | Marriage | School Problems | Too much sleep |
| Conflict | Guilt | Medical concerns | Self-control | Trauma |
| Confusion | Hallucinations | Memory problems | Self-esteem | Tremors |
| Crying | Harming self | Mood swings | Self-neglect | Unable to relax |
| Cutting/Burning | Headaches | Motivation | Separation | Unhappiness |
| Deaths | Health | Negative thoughts | Sexual assault | Using drugs to cope |
| Debt | Home conditions bad | Nervousness | Sexual concerns | Violence |
| Decision making | Hopelessness | Nightmares | Sexual conflicts | Weight Loss or Gain |
| Diminished Pleasure | Impulsiveness | Obsessions | Sexual difficulties | Withdrawal/Isolation |
| Dependence | Increase appetite | Often using aspirin or painkillers | | Work Problems |
| Depression | Indecision | | | Worrying |

Any Other Concerns: _____

When did these issues begin? _____

How would you like your relationship to be different as a result of therapy? _____



COUPLE'S INTAKE FORM FOR HIM

CONTACT INFORMATION FOR HIM

His Name _____ Date _____

Date of Birth _____ SS# _____

Telephone Numbers:

Home: _____ Work: _____ Cell: _____

Address: _____

Email: _____ Referred by: _____

Emergency Contact Information:

Name _____ Relationship _____

Telephone Numbers:

Home: _____ Work: _____ Cell: _____

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