Couples Intake Assessment Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Today's Date:___________________________________

General Information

Name: ____

(Last) (First) (Middle Initial) (Preferred)

Name of parent/guardian (if under 18 years)

____

(Last) (First) (Middle Initial)

Date of Birth: ___________/_______________/______________ Gender: [ ] Male [ ] Female

Address: Street and Number ____

City, State, Zip ____

Phone: Home - ____________________________________ Cell - ____________________________________

May we leave messages? [ ] Yes [ ] No

Email address: ____

**Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

Demographic Information

Race: ____________________________________ Language: ____________________________________

Ethnicity: _________________________________ Religion: ____________________________________

Cultural Considerations: ____

Education

High School: ____

(School) (Last Grade Completed) (Graduated? Y or N)

Post High School Education: ____

(School) (Last Grade Completed) (Graduated? Y or N)

Is or was school performance a concern for you? If yes, please explain:

____

____

Marital Status

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Other

Years Married: ____________________________________ Years Divorced: ____________________________________

Children:

(Name) (Age) (Sex) (Grade/Occupation) (Living at home) (Biological, Adopted, or Step)

____

____

____

____

____

Other household members currently living in the home with you:
(Name) (Age) (Sex) (Grade/Occupation) (Relationship to you)
____
____
____
____
____

Health History
Primary Physician: ____
Primary Physicians Phone: ___________________________ Date of last exam: ____________________
List any Allergies: ____
List any previous surgeries: ____
Are you currently taking any medications? [ ] Yes [ ] No If Yes, please list:
____
____
Have you ever been prescribed psychiatric medication? [ ] Yes [ ] No If Yes, please list:
____
____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health?
[ ] Poor [ ] Fair [ ] Good [ ] Very Good [ ] Excellent
Please list any specific problems you are currently experiencing:
____
____
How would you rate your current sleeping habits?
[ ] Poor [ ] Fair [ ] Good [ ] Very Good [ ] Excellent
Please list any sleep problems you are currently experiencing:
____
____
How many times a week do you generally exercise? _______________________________________
What types of exercise do you participate in? ____
Please list any difficulties you experience with your appetite or eating patterns:
____
____
Are you currently experiencing overwhelming sadness, grief, or depression? [ ] Yes [ ] No
If Yes, approximately how long? ____
Are you currently experiencing anxiety, panic attacks, or have any phobias? [ ] Yes [ ] No
If Yes, approximately how long? ____
Are you currently experiencing any chronic pain? [ ] Yes [ ] No
If Yes, where and how long? ____
Are you currently experiencing any physical characteristics or body image concerns? [ ] Yes [ ] No
If Yes, please explain? ____
Is sexual functioning an area of concern for you? [ ] Yes [ ] No
If Yes, please explain? ____

Substance Abuse

Do you drink alcohol more than once a week? [ ] Yes [ ] No If yes, how often? ________________________________

Is alcohol an area of concern for you? [ ] Yes [ ] No If yes, please explain? ____________________________________

How often do you participate in recreational drug use? [ ] Daily [ ] Weekly [ ] Monthly [ ] Never

Is recreational drug using an area of concern for you? [ ] Yes [ ] No If yes, please explain? -

____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.):

	Please check	List family member
Alcohol/Substance abuse	[ ] Yes [ ] No	
Anxiety	[ ] Yes [ ] No	
Depression	[ ] Yes [ ] No	
Domestic Violence	[ ] Yes [ ] No	
Eating Disorders	[ ] Yes [ ] No	
Obesity	[ ] Yes [ ] No	
Obsessive Compulsive Disorder	[ ] Yes [ ] No	
Schizophrenia	[ ] Yes [ ] No	
Suicide Attempts	[ ] Yes [ ] No	

Abuse History

Have you ever experienced physical, sexual, or emotional abuse? [ ] Yes [ ] No If yes, please explain:

____

Legal History

Do you have a history on any legal charges? [ ] Yes [ ] No If yes, please explain:

____

Are you currently on probation or parole? [ ] Yes [ ] No If yes, please explain:

____

Is treatment court ordered? [ ] Yes [ ] No If yes, please explain:

____

Employment

Are you currently employed? [ ] Yes [ ] No If yes, what is your current employment situation:

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

Couples Relationship

Have you ever been to couples counseling before? [ ] Yes [ ] No If yes, when and where? ____________________

____

What benefits are you looking to achieve?

[ ] Improve our communication	[ ] Reduce tension
[ ] Resolve conflicts and disagreements	[ ] Prevent separation or divorce
[ ] Understand my partner better	[ ] Learn “good” ways to fight
[ ] Stop hurting each other	[ ] Improve our sex and intimacy
[ ] Understand myself better	[ ] Decide whether we should separate

What best describes the current state of your relationship?

[ ] Partner is threatening to leave you	[ ] Neither is leaving but you have serious relationship problems
[ ] Partner has already left you	[ ] Our relationship has fallen into a rut
[ ] You are thinking of leaving partner	[ ] Not listed. Other: ______________________________________

What is the biggest issue in your relationship?

[ ] There is little to no affection and intimacy	[ ] Cheating or suspect of cheating has occurred
[ ] We fight too often	[ ] One or both of us feel bored or out of love in the relationship
[ ] We do not communicate effectively	[ ] Not listed. Other: ______________________________________

Marital Self Questionnaire

Do you experience your partner as being overly critical of you?	[ ] Often	[ ] Rarely	[ ] Never
Do you feel attacked or blamed by your partner for your personality style?	[ ] Often	[ ] Rarely	[ ] Never
Do you feel like your efforts to support your partner are unappreciated?	[ ] Often	[ ] Rarely	[ ] Never
Do you feel your partner discounts you or ignores you?	[ ] Often	[ ] Rarely	[ ] Never
Do you find yourself reacting negatively to each other through body language?	[ ] Often	[ ] Rarely	[ ] Never
Do you feel your partner is avoiding being responsible for their behavior?	[ ] Often	[ ] Rarely	[ ] Never
Does your relationship make you feel depressed or lonely?	[ ] Often	[ ] Rarely	[ ] Never
Are you experiencing your partner as unwilling to discuss relationship issues with you, becoming defensive or withdrawing?	[ ] Often	[ ] Rarely	[ ] Never