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Couple's Intake Form
The rules and limits of confidentiality apply to the information included in this form

Partner #1: _____

Social Security #: _____

Date of Birth _____

Address _____

_____

Phone Numbers: May I contact you at the following:
Home ( ) yes/no
Cell ( ) yes/no
Work ( ) yes/no
Email: _____ yes/no

Employer/School _____

Occupation: _____

How long on present job? _____

Last school grade completed_____

Primary Care Physician _____

Phone # _____

Emergency Contact _____

Phone # _____

Partner #2: _____

Social Security #: _____

Date of Birth _____

Address _____

_____

Phone Numbers: May I contact you at the following:
Home ( ) yes/no
Cell ( ) yes/no
Work ( ) yes/no
Email: _____ yes/no

Employer/School _____

Occupation _____

How long on present job? _____

Last school grade completed: _____

Primary Care Physician _____

Phone # _____

Emergency Contact _____

Phone # _____

Marital Status: _____

Living with spouse/partner? _____ Number of years together _____

Names of children (please include birthdates and names of parents):

_____ _____

_____ _____

_____ _____

_____ _____

Insurance Information

Health Plan/Insurance _____ Policy # _____

Phone # _____

Subscriber Name _____ Subscriber SS #_____

Mental Health Insurance (if different than above): _____

Major reasons for seeking help at this time: _____

_____

_____

_____

How long have you had these problems or symptoms?: _____

_____

Why did you decide to seek help now? _____

_____

What is different about the times when your relationship is going well? _____

_____

What do you see as your strengths, both individually and as a couple? _____

_____

_____

What have you tried already? _____

_____

Goals for Therapy: _____

_____

_____

Past or current psychiatric treatment: (name of therapist; type—individual, couple or family; year; helpful?)

_____

_____

_____

Please describe any significant incidents, traumas, developmental concerns, learning issues that would be helpful for me to know about anyone in the family : _____

_____

_____

Do either of you have any serious or chronic medical conditions or past surgeries? If yes, please explain:

_____

_____

Have either of you had any serious medical accidents or injuries, head injury or seizure history? Yes / No

If yes, please explain: _____

Do either of you take any medications? Yes / No
If yes, please list: _____

_____

_____

Does Partner 1 use alcohol? Yes / No Does Partner 2 use alcohol? Yes / No

How much per day/week _____
Age when started drinking? _____
Last drink taken (time and amount): _____

Does Partner 1 use drugs? Yes / No Does Partner 2 use drugs? Yes / No

What kind(s): _____
Amount/frequency: _____
Age started using: _____
Last use (time and amount): _____

Do either of you feel you have a problem with:
Alcohol: Yes / No
Drugs: Yes / No
If so, explain: _____

Previous treatment programs (dates, locations, if possible): _____

_____

Has drinking/drug use caused problems in the family or with relationships? Yes / No
Has drinking/drug use caused job problems? Yes / No
Is it difficult for family member to stop or control the amount used? Yes / No
Have you ever been arrested for a D.U.I (driving under the influence) or other drug related offense(s)? Yes / No

Does either or both of you use tobacco products? Yes / No

How many cups of caffeinated beverages are consumed per day (coffee, tea, soda, energy drinks, etc):

Have you had any financial problems, legal difficulties/problems or previous incarceration? Yes / No
If yes, dates and details:

Have relatives/significant others had psychiatric symptoms or drug or alcohol problems? Yes / No
Please indicate Partner 1 or Partner 2

Have any family members had problems with criminal offenses or been incarcerated? Yes / No

If yes, who, why?

Others living in the home? (names, ages, relation)

Additional Information: