CLIENT INTAKE FORM – COUPLES/CO-PARENTS

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Please complete all pages of this form.

Client's Full Name:_____

Date of Birth: _____

Gender identification:_____ Identified Pronouns:_____

Referred by: _____ Primary Care Physician: _____

Client lives with: _____

Client's Address: _____

_____

Home Phone: _____ ☐day ☐evening OK to leave msg? ☐YES ☐NO

Work Phone: _____ ☐day ☐evening OK to leave msg? ☐YES ☐NO

Cell Phone: _____ ☐day ☐evening OK to leave msg? ☐YES ☐NO

Educational Level: _____ Occupation: _____

Employer: _____

How would you rate your job satisfaction? _____

PRIMARY CONCERNS:

Briefly describe your primary concerns and why you have sought counseling at this time.

_____

_____

_____

_____

_____

GOALS FOR THERAPY

What would you like to see happen as a result of your work here? _____

_____

_____

_____

MEDICAL HISTORY

How would you rate your general health? ☐Excellent ☐Good ☐Fair ☐Poor

Approximately when was your last comprehensive medical evaluation? _____

Have you ever been hospitalized for psychological reasons? ☐Yes ☐No

If yes, when and where? _____

_____

Please check whether you currently have, or have ever had any of the following:

__drug/alcohol abuse	__sleeping problems	__changes in appetite	__flashbacks
__hormone disorder	__frequent headaches	__epilepsy or seizures	__ulcers
__disturbing thoughts	__lack of interest	__sexual abuse	__depression
__memory problems	__low self-esteem	__speech problems	__confusion
__irritability	__emotional abuse	__hearing problems	__head trauma
__bowel problems	__irregular heartbeat	__visual problems	__bedwetting
__suicidal ideations/attempts	__feelings of hopelessness	__homicidal thoughts	__weight loss
__sexual concerns	__difficulty managing anger	__mood swings	__asthma
__chronic illnesses	__family/relationship issues	__stress	__anxiety
__physical abuse or neglect	__panic attacks	__serious infection	__allergies
__racing thoughts	__frequent stomachaches	__feelings of paranoia	
__broken bones	__school/work difficulties	__blood pressure concerns	
__frequent or uncontrolled crying		__difficulty concentrating	
__problems with coordination		__communication problems	
__self-destructive or self-injurious behavior		__ phobias:_____	

__other physical or emotional issues (please describe):

_____

_____

Are you currently taking medication? ☐ Yes ☐ No

If yes, please list them here: (Use the bottom of the page if more space is needed.)

Medication: _____ Dosage: _____ Date Started: _____

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Medication: _____ Dosage: _____ Date Started: _____

List other substances that you consume, including alcohol, caffeine, marijuana, illicit drugs, tobacco, etc.

_____

_____

List any serious illnesses for which you have required hospitalization or surgical operation:

(Use the bottom of the page if more space is needed.)

Illness	Year	Doctor	Hospital

List any psychological, substance abuse, or psychiatric services you have received:

(Use the bottom of the form if more space is needed.)

Service	Year	Doctor	Issue at Time

2-WEEK WELL-BEING

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.
Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3.

	Over the last 2 weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	I have felt cheerful and in good spirits	☐5	☐4	☐3	☐2	☐1	☐0
2	I have felt calm and relaxed	☐5	☐4	☐3	☐2	☐1	☐0
3	I have felt active and vigorous	☐5	☐4	☐3	☐2	☐1	☐0
4	I woke up feeling fresh and rested	☐5	☐4	☐3	☐2	☐1	☐0
5	My daily life has been filled with things that interest me	☐5	☐4	☐3	☐2	☐1	☐0

RELATIONSHIP INFORMATION

Relationship/Marital Status: (check all that apply)

☐Single ☐Involved ☐Engaged ☐Cohabitating ☐Remarried ☐Married ☐Separated ☐Divorced

☐Widowed ☐Open Relationship ☐Monogamous ☐Polyamorous ☐Other: _____

What are the top 3 concerns you have about your relationship with your partner/co-parent?

1. _____

2. _____

3. _____

Name at least one thing you could do personally to strengthen your relationship.

_____

_____

_____

_____

_____

_____

Briefly describe your satisfaction with your relationship over time.

_____

_____

_____

_____

_____

_____

FAMILY INFORMATION

Names and ages of other individuals residing in your home:

Name	Age	Relationship to Client

List **any close family members** who have experienced significant medical problems, mental health issues or substance abuse. Write the name and issue, for example "Mom – high blood pressure".

Medical Problems of Family Members: (Include blood pressure, heart problems, diabetes, cancer, etc)

Past: _____

Present: _____

Mental Health Issues of Family Members: (Include depression, anxiety, panic, suicide, etc)

Past: _____

Present: _____

Legal Substance Use of Family Members: (Include alcohol, marijuana, tobacco, caffeine, prescription drugs, etc)

Past: _____

Present: _____

Illicit Substance Use of Family Members:

Past: _____

Present: _____

EMERGENCY INFORMATION

In the case that I think you are experiencing a medical emergency during a session (either physical or psychological), I will call our local emergency number. If you would like me to also contact someone else, list them here:

Name_____ Phone _____

Relationship to Client _____