HOPE & HARBOR

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COUPLES COUNSELING INTAKE FORM

Welcome to It's Just Therapy. Please note that this information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

PERSONAL INFORMATION

Name: _____
Date of Birth: _____ Age: _____ Male _____ Female _____
Address: _____
City: _____ State: _____ Zip: _____

Phone (Cell): _____ Messages okay?____ Text reminder okay?_____
Phone (Work): _____ Messages okay?____
Phone (Home): _____ Messages okay?____
Email: _____

Relationship Status: (check all that apply)
_____ Married _____ Dating _____ Separated _____ Divorced _____ Cohabitating _____ Living Together _____ Living Apart

Education / Employment Information

Last grade completed in School: _____
Are you currently employed?¨ Yes¨ No Company Name: _____
Present Occupation: _____

Please check all that apply to your current situation or struggle:

□ Stress
□ Anger
□ Fears
□ Finances
□ Parenting
□ Guilt
□ Anxiety
□ Depression

□ Addiction
□ Hopelessness
□ Extreme sadness
□ Physical pain
□ Memory problems
□ Grief and loss
□ Impulsive behavior
□ Financial problems
□ Legal matters
□ Family conflict
□ Obsessions or compulsions
□ Trouble concentrating
□ Self esteem problems
□ Relational problems
□ Trouble making decisions
□ Changes in sexual interest or function
□ Thoughts about harming others
□ Lack of enjoyment of usual activities
□ Other: _____

Relationship History

How long have you been in the current relationship? _____

Have you ever been separated or previously divorced from your current partner? _____
_____

Have you been married before? ¨Yes¨No I Yes, how many times? _____ Do you have children? ¨Yes¨No If yes, how many? _____

List everyone currently living in your home:

Name	Age	Birthdate	Relationship	Occupation

What sorts of problems are you currently experiencing in the relationship? Please be specific (communication about money, disagreements over childrearing, etc.) _____

_____
_____
_____
_____
_____
_____

Have you previously sought help for these problems outside of your extended family? If so, what kind of help have you engaged? (religious or couples' counseling) _____
_____
_____

Has anything helped resolve the problem? _____
_____
_____

Has anything intensified the problem? _____
_____
_____

What would describe your daily relationship with each other? Check one.
Cool and distant | Heated and argumentative | Friendly and comfortable

How frequently have you engaged in sexual relations in the past month? _____ times

How enjoyable is your sexual relationship?

1 2 3 4 5 6 7 8 9 10 (1 - being extremely unpleasant and 10 - being extremely pleasant)

How satisfied are you with the frequency of your sexual relations?
1 2 3 4 5 6 7 8 9 10 (1 - being extremely unsatisfied and 10 - extremely satisfied)

What is your current level stress coming from outside the relationship?

1 2 3 4 5 6 7 8 9 10

What is your current level of stress inside the relationship?

1 2 3 4 5 6 7 8 9 10

Please rate your current level of happiness in the relationship.

1 2 3 4 5 6 7 8 9 10

Family History

Who did you live with until you were 18 years of age? _____
_____

Mother's current age _____ If deceased, her age at death? _____ Your age at time of her death?_____

Father's current age _____ If deceased, his age at death? _____ Your age at time of his death? _____

Did your parents ever divorce? Yes | No
If yes, how old were you at the time of your parents divorce? _____

Did you have a stepparent before you were 18 years of age? ¨Yes¨No
Were you adopted? ¨Yes¨No If yes, at what age? _____ Do you have adopted siblings? ¨Yes¨No If yes, at what age? _____

Were you ever in foster care or a similar living situation? ¨Yes¨No
If yes, at what age? _____ for how long?_____

Medical History

Are you presently being treated for any health problems? Yes | No
If yes, please explain: _____
_____

What prescribed medications do you take? _____
_____

What over the counter (non-prescription) or herbal medications do you take? _____
_____

Physician's name _____ Phone # _____
How would you rate your health?

¨Excellent | Good | Average | Poor | Failing

Do you or your family members currently have or have ever had any of the following:

Please check all that apply

	Now	Past	Family		Now	Past	Family		Now	Past	Family
Asthma				Immune System Problems				Tuberculosis			
Heart Disease				Chronic Fatigue Syndrome				Epilepsy			
Headaches				Head Injury				High Blood Pressure			
Digestive Disorders				Arthritis				Thyroid Disorder			
Cancer				Vision Problems				Multiple Sclerosis			
Diabetes				Hearing Problems				Pregnancy			
Breathing Problems				Fibromyalgia				Stroke			
Alcohol or Drug Abuse				Depression				Other			

Do you drink alcohol?
¨Never _____ drinks per week

Do you drink caffeinated beverages?
¨Never _____ drinks per week

Do you smoke marijuana? ¨Yes ¨In the Past ¨No
If yes, how often? _____
How often do you engage in recreational drug use?
¨Daily ¨Weekly ¨Monthly ¨Infrequently ¨Never

Do you use nicotine?¨ Yes¨ No
If yes, how many packs a day and for how long? _____

Have you ever had a problem with gambling? ¨Yes¨In the Past¨No Do you have problems sleeping? ¨Yes¨No

Do you have problems with eating or with food? ¨Yes¨No
If yes, please describe: _____
_____

Psychological History

What significant life changes or stressful events have you experienced recently?
_____
_____

What significant traumatic events have you experienced in your life?
_____
_____

Have you ever been to in counseling before? ¨Yes¨No
If yes, when and with whom? _____

How helpful was it? **Please circle one**
1- - - - - - - - - - - - - -2- - - - - - - - - - - - - -3- - - - - - - - - - - - - -4- - - - - - - - - - - - - -5 Positive Somewhat Neutral Somewhat Negative

Positive Negative

Did anyone in your family die before you were 18 years old? ¨Yes¨No
If yes, who, and how old were you? _____

Other family deaths? _____
_____

Have you ever been hospitalized for a mental illness? ¨Yes Year _____¨No 5

Have you ever been diagnosed with a mental illness?¨ Yes Year _____¨ No
If yes, please explain: _____
_____

Has a family member been diagnosed/hospitalized with a mental illness? ¨Yes Year _____ ¨No
If yes, please explain: _____
_____

Have you been abused or assaulted?
Did you witness abuse between your parents? Did you witness abuse between parent and child?

¨ Yes¨ Yes¨ Yes

¨ No¨ No¨ No

¨ Don't Remember¨ Don't Remember¨ Don't Remember

Have you had suicidal thoughts in the past 2 months? ¨Yes¨No
Have you ever attempted suicide? ¨Yes¨No
If yes, how many times? _____ When and how? _____
_____

Has anyone in your family ever attempted or succeeded at suicide? ¨Yes¨No
If yes, who? _____

Have you ever had any legal issues (criminal or civil)? ¨Yes¨No
If yes, please explain what the issue was and when you had it. (example: DUI, divorce, identity theft, etc.) _____
_____

Do you have any friends or family with whom you discuss your deepest problems?¨ Yes¨ No
Who? _____

Describe any of your important values, beliefs, religious training, and/or traditions:
_____
_____
_____

Please list the goals you hope to accomplish through counseling:
1. _____

2. _____

3. _____

____ _____________________

Signature

Date