# Couple Intake (MANDATORY for each partner)

** indicates a required field*

Please fill this out yourself (separately).

### * Who referred you? What is their contact information?

### * Marital status

- ○ The two of you married and live together
- ○ The two of you are married and do NOT live together
- ○ The two of you are separated
- ○ The two of you are divorced
- ○ The two of you are NOT married and living together
- ○ The two of you are NOT married and are NOT living together

### * How long together?

### How long married? (if married)

## * Your basic information

Name

Age

Cell phone

Home phone

Work phone

Email address

Occupation

Home address

## * Your partner's basic information

Name

Email

Cell phone

## * Do you take any medications?

- Yes
- No

*** Are you currently seeing an individual therapist?**

- ○ Yes
- ○ No

*** Do you drink alcohol?**

- ○ Yes
- ○ No

*** Do you use recreational drugs?**

- ○ Yes
- ○ No

*** Do you have suicidal thoughts?**

- ○ Yes
- ○ No

*** Have you ever attempted suicide?**

- ○ Yes
- ○ No

*** Do you have thoughts or urges to harm others?**

- ○ Yes
- ○ No

*** Have you ever been hospitalized for a psychiatric issue?**

- ○ Yes
- ○ No

*** Is there a history of mental illness in your family?**

- Yes
- No

*** Any major medical issues?**

- Yes
- No

*** Any disabilities I should know about?**

- Yes
- No

*** Describe your current living situation. Do you have children living with you? If so, how many? What are their ages and gender? Are they stepchildren?**

*** What are your goals for counseling?**

*** COUPLE: What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can**

*** COUPLE: Any history of violence in your relationship?**

- ○ Yes
- ○ No

*** COUPLE: Do agree to come in together and not alone? (I do not see partners alone)**

- ○ Yes
- ○ No