Couples Intake Form

Please have each member of the couple bring their own completed intake form to the first session

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Name: ____

Mailing Address: ____

Birthdate: ____________________ Gender: ______________

Partner's Name: ____

How did you hear about us? ____

Start of the relationship: ______________ When you married: ______________

When you lived together: ______________ Start of distress: ______________

Names & ages of children: ____

In case of emergency, I authorize Bob & Karin Matthews PLLC to contact ______________ by telephone at (______) ___________________.

My relationship to this contact is:____

Health Related Information:

Name of Personal Physician: ________________________________

(We would only contact your doctor with your permission.)

Phone Number: ________________________________

List any specific health problems you are currently experiencing:

Are you currently taking any prescribed medications? Y / N

If yes, then please explain/describe (e.g. current dosage, length of time taken):

List any psychiatric/mental health medications you have taken including dosage and period of time taken (Other than listed above):

List any supplements or vitamins that you have taken in support of mental health and the circumstances of your use:

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N
If yes, please give the caregiver's name, when the therapy took place, and briefly explain the nature of the problem:

Have you ever been hospitalized for a mental health condition? Y / N
If yes, please give the date and briefly explain the nature of the problem:

Have you ever been in a drug or alcohol treatment program? Y / N
If yes, please give the facility, length of time in treatment and outcome:

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 any that apply: Name & Relationship of Family Member(s)

☐ Alcohol/Substance Abuse
☐ Anxiety
☐ Depression
☐ Domestic Violence
☐ Eating Disorders
☐ Obesity
☐ Bipolar
☐ Borderline Personality Disorder
☐ Obsessive Compulsive Behavior
☐ Schizophrenia
☐ Suicide Attempts
☐ Suicide

Lifestyle Information:

Please check of any of the following struggles that pertain to you:

☐ Anxiety	☐ Depression	☐ Fears/Phobias	☐ Eating Disorders
☐ Sexual Problems	☐ Suicidal Thoughts	☐ Separation/Divorce	☐ Relationships
☐ Finances	☐ Drug/Alcohol Use	☐ Career Choices	☐ Anger
☐ Self-Control	☐ Unhappiness	☐ Insomnia	☐ Religious Matters
☐ Work/Stress	☐ Health Problems	☐ Cutting/ Self-Mutilation	☐ Disturbing or Repetitive Thought Patterns

How much sleep are you getting each night on average? ________ hours
Do you have any concerns regarding sleep or rest? Y / N

How much alcohol do you consume? How often?

What recreational drugs are you using? How much? How often?

Do you think you have a problem with either alcohol or drugs? Y / N

Have you ever attempted or considered suicide, wished you were dead or wanted to go to sleep and not wake up? Y / N
If yes, how recently and please provide some details:

Describe any recent weight gain or loss and the circumstances that surround it:

How many times per week do you generally exercise? _______
Please list types of exercise in which you participate:

Are you currently experiencing overwhelming sadness, grief, or depression? Y / N
If yes, for approximately how long?

Are you currently experiencing anxiety, phobias, or having panic attacks? Y / N
If yes, please describe, and for how long?

Are you currently experiencing any chronic pain? Y / N
If yes, please describe:

Are you currently employed? Y / N
If yes, what is your current employment situation? If no, please describe your circumstance.

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

Do you consider yourself to be spiritual or religious? Y / N
If yes, describe your faith or belief:

Relationship Information:

Please circle your current level of commitment, confidence and distress in your relationship:

Level of commitment	Level of confidence	Level of distress
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Low High	Low High	Extremely Happy Extremely Unhappy

Describe the frequency and intensity of conflict in your relationship:

List the top 3 recurring themes that continue to surface in conflict with each other:

If conflict has ever become physical within your relationship, describe the situation:

Describe your level of satisfaction with your sexual relationship:

Client Name	Client Signature	Date