COUPLE INTAKE FORM

Please provide the following information. It will be handled in the same manner as our therapy in regard to confidentiality.

□ Married _____ years □ Living together _____ years □ Separated _____ months

PARTNER 1'S INFORMATION	PARTNER 2'S INFORMATION
Name:_____	Name:_____
Birth Date: ____/____/_____ Age: _____	Birth Date: ____/____/_____ Age: _____
Address: _____	Address: _____
_____	_____
Cell Phone: _____	Cell Phone: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Permission to leave message at: Home/ Work/ Cell	Permission to leave message at: Home/ Work/ Cell
Email: _____	Email: _____
Permission to email you: □ Yes □ No	Permission to email you: □ Yes □ No
Emergency Contact: _____	Emergency Contact: _____
Emergency Phone: _____	Emergency Phone: _____
Previous Counseling: □ Yes □ No # Therapists: ___	Previous Counseling: □ Yes □ No # Therapists: ___
Previous Therapist's Name: _____	Previous Therapist's Name: _____
Previous Therapist's Name: _____	Previous Therapist's Name: _____
Number of Previous Marriages: _____	Number of Previous Marriages: _____

Child's Name: _____ Age: _____ □ Partner 1 □ Partner 2 □ Adopted

Child's Name: _____ Age: _____ □ Partner 1 □ Partner 2 □ Adopted

Child's Name: _____ Age: _____ □ Partner 1 □ Partner 2 □ Adopted

Child's Name: _____ Age: _____ □ Partner 1 □ Partner 2 □ Adopted

Child's Name: _____ Age: _____ □ Partner 1 □ Partner 2 □ Adopted

Child's Name: _____ Age: _____ □ Partner 1 □ Partner 2 □ Adopted

Child's Name: _____ Age: _____ □ Partner 1 □ Partner 2 □ Adopted

Are you currently receiving psychiatric services: Partner 1: □ Yes □ No Partner 2: □ Yes □ No

MD's Name: Partner 1 _____ Partner 2 _____

How did you hear about Authentic Living? _____

Referred by: _____

TO BE COMPLETED BY PARTNER 1

PARTNER 1'S OCCUPATIONAL INFORMATION

Are you currently employed: □ Yes □ No If no, how long have you been out of work: _____

If yes, current employer/position: _____

If yes, are you happy at your current position: _____ Any stressors: _____

_____

PARTNER 1'S HEALTH AND SOCIAL INFORMATION

How is your physical health at present: □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

List any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

_____

List any current emotional stressors: (e.g. loss, grief, relocation, financial, difficult family member, etc.):

_____

_____

Are you having trouble sleeping: □ Yes □ No

If yes, check where applicable: □ Too little □ Too much □ Poor quality □ Disturbing dreams □ Other

How many times per week do you exercise: _____ Approximately how long each time: _____

Difficulty with appetite or eating habits: □ Yes □ No □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months: □ Yes □ No

Do you regularly use alcohol: □ Yes □ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period: _____

How often do you engage in recreational drug use: □ Daily □ Weekly □ Monthly □ Rarely □ Never

Has anyone told you they were concerned about your alcohol/drug use: □ Yes □ No

Have you had suicidal thoughts recently: □ Frequently □ Sometimes □ Rarely □ No

Have you had them in the past: □ Yes □ No If yes, have you attempted: □ Yes □ No

Currently taking prescribed medication (antidepressants or others): □ Yes □ No

If yes, please list: _____

If no, have you previously: □ Yes □ No If yes, please list: _____

On a scale of 1-10 (with 10 high), how would you rate the quality of your current relationship: _____

PARTNER 1'S MENTAL HEALTH HISTORY

In the last year, what significant life changes or stressors have you experienced: _____

_____

HAVE YOU EVER EXPERIENCED:

□ Yes	□ No	Extreme Depressed Mood	□ Yes	□ No	Alcohol/Substance Abuse
□ Yes	□ No	Wild Mood Swings	□ Yes	□ No	Frequent Body Complaints
□ Yes	□ No	Rapid Speech	□ Yes	□ No	Eating Disorder
□ Yes	□ No	Extreme Attacks	□ Yes	□ No	Body Image Problems
□ Yes	□ No	Phobias	□ Yes	□ No	Repetitive Thoughts (i.e. obsessions)
□ Yes	□ No	Sleep Disturbances			
□ Yes	□ No	Hallucinations	□ Yes	□ No	Repetitive Behaviors (i.e. frequent hand washing, checking, etc.)
□ Yes	□ No	Unexplained Losses of Time/Memory Lapses	□ Yes	□ No	Homicidal Thoughts
□ Yes	□ No	Chronic, Unexplained Pain	□ Yes	□ No	Suicide Attempt

PARTNER 1'S FAMILY MENTAL HEALTH HISTORY

Have immediate family members or relatives experienced any of the following (if yes, list relationship):

□ Yes	□ No	Alcohol/Substance Abuse	_____
□ Yes	□ No	Depression	_____
□ Yes	□ No	Bipolar Disorder	_____
□ Yes	□ No	Anxiety or Panic Attacks	_____
□ Yes	□ No	Schizophrenia	_____
□ Yes	□ No	Suicide Attempts	_____
□ Yes	□ No	Chronic or Significant Physical Illness	_____
□ Yes	□ No	Learning Disability	_____
□ Yes	□ No	Trauma History	_____

PARTNER 1'S OTHER INFORMATION

Do you consider yourself to be religious: □ Yes □ No If yes, what is your faith: _____

If no, do you consider yourself to be spiritual: □ Yes □ No

How do you describe your racial, ethnic, or cultural background?_____

_____

How would you describe your sexual/romantic orientation?_____

What effective coping strategies have you've learned: _____

_____

_____

_____

What are your strengths: _____

_____

_____

Brief description of your experience growing up (relationship with parents/siblings, sexual or physical abuse, etc.): _____
_____
_____
_____
_____

Is there anything else you'd like me to know: _____
_____
_____
_____
_____

I have received, read and understand the Therapy Agreement and Privacy Policy.

Partner 1's Signature: _____ Date: _____

PARTNER 1'S TREATMENT GOALS

Please complete as best you can. If you are unsure of your answers, this can also be completed in session.

What brings you to therapy and why now?
_____
_____
_____
_____

What are your goals for therapy?
_____
_____
_____
_____

How will you know that you're making progress?
_____
_____
_____
_____

_____ _____
Client Signature **Date**

_____ _____
Therapist Signature **Date**

TO BE COMPLETED BY PARTNER 2

PARTNER 2'S OCCUPATIONAL INFORMATION

Are you currently employed: □ Yes □ No If no, how long have you been out of work: _____

If yes, current employer/position: _____

If yes, are you happy at your current position: _____ Any stressors: _____

_____

PARTNER 2'S HEALTH AND SOCIAL INFORMATION

How is your physical health at present: □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

List any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

_____

List any current emotional stressors: (e.g. loss, grief, relocation, financial, difficult family member, etc.):

_____

_____

Are you having trouble sleeping: □ Yes □ No

If yes, check where applicable: □ Too little □ Too much □ Poor quality □ Disturbing dreams □ Other

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Do you regularly use alcohol: □ Yes □ No

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Has anyone told you they were concerned about your alcohol/drug use: □ Yes □ No

Have you had suicidal thoughts recently: □ Frequently □ Sometimes □ Rarely □ No

Have you had them in the past: □ Yes □ No If yes, have you attempted: □ Yes □ No

Currently taking prescribed medication (antidepressants or others): □ Yes □ No

If yes, please list: _____

If no, have you previously: □ Yes □ No If yes, please list: _____

On a scale of 1-10 (with 10 high), how would you rate the quality of your current relationship: _____

PARTNER 2'S MENTAL HEALTH HISTORY

In the last year, what significant life changes or stressors have you experienced: _____

_____

HAVE YOU EVER EXPERIENCED:

□ Yes	□ No	Extreme Depressed Mood	□ Yes	□ No	Alcohol/Substance Abuse
□ Yes	□ No	Wild Mood Swings	□ Yes	□ No	Frequent Body Complaints
□ Yes	□ No	Rapid Speech	□ Yes	□ No	Eating Disorder
□ Yes	□ No	Extreme Attacks	□ Yes	□ No	Body Image Problems
□ Yes	□ No	Phobias	□ Yes	□ No	Repetitive Thoughts (i.e. obsessions)
□ Yes	□ No	Sleep Disturbances			
□ Yes	□ No	Hallucinations	□ Yes	□ No	Repetitive Behaviors (i.e. frequent hand washing, checking, etc.)
□ Yes	□ No	Unexplained Losses of Time/Memory Lapses	□ Yes	□ No	Homicidal Thoughts
□ Yes	□ No	Chronic, Unexplained Pain	□ Yes	□ No	Suicide Attempt

PARTNER 2'S FAMILY MENTAL HEALTH HISTORY

Have immediate family members/relatives experienced the following (if yes, list relationship):

□ Yes	□ No	Alcohol/Substance Abuse	_____
□ Yes	□ No	Depression	_____
□ Yes	□ No	Bipolar Disorder	_____
□ Yes	□ No	Anxiety or Panic Attacks	_____
□ Yes	□ No	Schizophrenia	_____
□ Yes	□ No	Suicide Attempts	_____
□ Yes	□ No	Chronic or Significant Physical Illness	_____
□ Yes	□ No	Learning Disability	_____
□ Yes	□ No	Trauma History	_____

PARTNER 2'S OTHER INFORMATION

Do you consider yourself to be religious: □ Yes □ No If yes, what is your faith: _____

If no, do you consider yourself to be spiritual: □ Yes □ No

How do you describe your racial, ethnic, or cultural background?_____

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How would you describe your sexual/romantic orientation?_____

What effective coping strategies have you've learned: _____

_____

_____

_____

What are your strengths: _____

_____

_____

Brief description of your experience growing up (relationship with parents/siblings, sexual or physical abuse, etc.): _____
_____
_____
_____
_____

Is there anything else you'd like me to know: _____
_____
_____
_____
_____

I have received, read and understand the Therapy Agreement and Privacy Policy.

Partner 1's Signature: _____ Date: _____

PARTNER 2'S TREATMENT GOALS

Please complete as best you can. If you are unsure of your answers, this can also be completed in session.

What brings you to therapy and why now?
_____
_____
_____
_____

What are your goals for therapy?
_____
_____
_____
_____

How will you know that you're making progress?
_____
_____
_____
_____

_____ _____
Client Signature **Date**

_____ _____
Therapist Signature **Date**