Initial Intake Questionnaire – Couples Therapy

The following questionnaire is designed to gather initial intake information that is needed to open your case and to gather initial assessment information regarding your treatment needs. Please complete this form to the best of your ability. If you have any questions regarding the contents of this questionnaire or are not comfortable answering a particular question, please leave the item blank or ask for assistance. Thank you!

Referral Source:____ **Today's Date:**__________________

Client Name:____ **Date of Birth**:__________________

Spouse/Partner Name:____ **Date of Birth:**__________________

Address of Primary Residence:

____

____

____

Home Phone: _________________________________

Please check if OK to leave a message at this number ❑

Cell Phone: _________________________________

Please check if OK to leave a message/text at this number ❑

Spouse/Partner's Address (if different)

____

____

____

Home Phone: _________________________________

Please check if OK to leave a message at this number ❑

Cell Phone: _________________________________

Please check if OK to leave a message/text at this number ❑

Please list names and ages of other family members currently living in the home:

____ ____

____ ____

____ ____

General Relationship History:

How long have you and your spouse/partner been together?____

If married, how many years?_______________ How long did you date prior to marriage?____________________

How did you meet your spouse/partner?____

____

How would you describe your relationship?____

____

How would your spouse/partner describe your relationship?____

____

Reason for seeking couples therapy at this time –

Please include the following information:

1. Length of time problem/issue has been occurring

2. How is your relationship issue currently impacting your individual functioning?

3. What attempts have been made to address your presenting issue prior to seeking therapy?

4. How you hope therapy will help your relationship?

Education and Employment

Highest Education Received:____

Occupation:___________________________________Name of Employer:_______________________________

Are you experiencing any current difficulties with occupational performance? If yes, please explain:

Spouse's/Partner's Highest Education Received:____

Spouse's/Partner's Occupation:__________________________________Name of Employer:___________________

Is your spouse/partner experiencing any current difficulties with occupational performance? If yes, please explain:

Family Mental Health Background

*Please answer the following questions as related to both yourself and your spouse/partner's family background.

Have you or anyone in your family received mental health services before?______________________________

If yes: Who received services?____

Who provided these services?____

For how long did you and/or your family members participate in mental health services?_________________

What issue(s) was the focus of treatment at that time?___

How would you describe the experience you and/or your family members have had with mental health services? (i.e., positive, helpful, not helpful)

Is a psychiatrist currently treating you or any of your family members?_________________________________

If yes, please identify the person who is currently being treated, the reason for treatment, the psychiatrist name and the type (name is known) of medication:

Have you or anyone in your family ever been hospitalized for mental health reasons? ________________________

If yes, please identify who in your family has been hospitalized, the date(s), reason(s) and location(s):

____

Family Medical Background

Have you or anyone in your family ever been diagnosed with a serious medical condition? Please describe:

Are you or anyone in your family currently experiencing any medical/physical symptoms that are related to a mental, emotional, or stress-related condition? Please describe:

Current or Past Family Stressors

Is there a history of mental illness in your family? Please describe:

Is there a history of addiction in your family? Please describe:

Is there a history of abuse or violence in your family? Please describe:

Additional Information

Is there any additional information that you feel is important to provide at this time?

Thank you for taking the time to complete this form to the best of your ability.