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COUPLES INTAKE

IDENTIFYING INFORMTATION

Name 1: _____ Age: _____
Name 2: _____ Age: _____

Address: _____

City/State_____Zip:_____

Cell Phone 1:_____Cell Phone 2:_____

Email Address 1: _____ Email Address 2:_____

PERSONAL INFORMATION

SINGLE MARRIED SEPARATED WIDOWED

How Long in Relationship? _____

Emergency Contact:_____

Emergency Contact Phone Number: _____ Relationship to You: _____

CURRENT CONCERNS

Why are you seeking therapy right now?

_____
_____
_____
_____

How long have these problems occurred?

_____

Problems perceived to be (Please circle):
Very serious Somewhat Serious Not Very Serious

What happened that makes you seek help at this time?

_____
_____
_____
_____

What changes would you like to see in your life?

_____
_____
_____
_____

What changes would you like to see in the relationships around you?

_____
_____
_____
_____

Where are you getting stuck preventing change to occur?

_____
_____
_____
_____

What habits and patterns would you like to change?

_____
_____
_____
_____

What are your major stressors at the present time, if any?

_____
_____
_____
_____

CURRENT FAMILY SITUATION:

Who do you currently reside with?

_____
_____

Have there been any recent changes in your family or extended family?

_____
_____

HEALTH OF FAMILY MEMBERS:

List all the family who have had a history of depression, ADHD, anxiety, mood disorder, drug/alcohol abuse, behavioral problems, legal problems, or other psychological problems:

Name:	Relation:	Mental Health:	Drugs / Alcohol:	Legal:	Other:

*Please list addition family members on the back of this page

HEALTH INFORMATION:

Note all health problems you have experienced currently or in the past:

Age		Age		Age	
	High Fever		Dental Problems		Pneumonia
	Weight Problems		Flu		Allergies
	Cancer		Meningitis		Convulsions
	Unconsciousness		Concussions		Head Injury
	Fainting		Dizziness		Tonsils Out
	Vision Problems		Hearing Problems		Earaches
	Skin Problems		Asthma		Headaches
	Stomach Problems		Accident Prone		Anemia
	High Blood Pressure		Low Blood Pressure		Sinus Problems
	Heart Problems		Hyperactivity		STD
	Infectious Disease		Other Illnesses		

If yes to any of the above, please explain:

_____

_____

Have either of you ever been admitted to a hospital? Yes No
If yes, please explain:

_____

_____

Have either of you ever seen a therapist/psychiatrist before? Please explain:

_____

_____

Are either of you currently on any medication?

_____

_____

If yes, please explain:

Medication:	Reason for Medication:	Dose:	How long:

*Please list additional information on the back of this page

Primary Care Physician:_____Phone Number: _____

Primary Care Physician:_____Phone Number: _____

PSYCHOSOCIAL HISTORY:

Describe the nature of your relationships with friends/peers/co-workers:

_____

_____

_____

_____

Describe your hobbies or ways that you like to spend your free time:

_____

_____

_____

_____

Describe your strengths as a couple:

Describe your level of satisfaction with where you are in life right now:

Describe how you typically respond in times of stress or conflict:

Who are the people in your life that are your support systems?

Describe any additional information that would be beneficial for me to know in us working together:

Client Signature Date

Client Signature Date

*All content is confidential with the Bay Area Mindfulness and Therapy Center