Couples Counseling Intake Form - Office of Jennifer F. D'Agostino, MS, LMHC, NCC

PERSONAL INFORMATION **Today's Date:** ______________**Preferred Session Day & Time:** ______________

First Name: ________________________**M.I.** ________**Last Name:** ____

DOB: ______________________ **Age:** __________________ **Gender:** ____________________

Street Address: ____ **City**: ____

State: _______________________**Zip**: _____________ **Cell:** ____

Home/Work Phone: ____ **Ok to leave a message?** ___ yes ___ no

Email: ____ **Partner's Email:** ____

Partner's Full Name: ____**DOB:** _______________________ **Age:** ______________

Gender: ____________________________ **Partner's Cell Phone:** ___________________**Ok to leave message?** ___y ___n

Emergency Contact Name: __________________________ **Phone:** ___________________ **Relationship:** _______________

Relationship Status - Check all that apply: ___ Married ___ Separated ___ Divorced ___ Dating ___ Cohabitating

___ Living Together ___ Living Apart **Length of Time in Relationship:** _______________________________________

Highest Education Level: ___ Did not finish High School ___ High School Grad ___ Some College no degree

___ Trade School ___ Associate's ___ Bachelor's ___ Master's ___ Doctorate **Field of Study:** ______________________

Occupation: _____________________________________ **Partner's Occupation:** _____________________________________

Partner's Highest Education Level: ___ Did not finish High School ___ High School Grad ___Some College no degree

___ Trade School ___ Associate's ___ Bachelor's ___ Master's ___ Doctorate **Field of Study:** ______________________

Describe Current Financial Situation: ____

Are you employed? _________________________________ **Is your partner employed?** ____________________________

Reason(s) for Seeking Counseling: ____

____

____

How long has this been a problem for you? ____

What have you already done to deal with these difficulties? ____

Goals You Wish to Achieve in Counseling: ____

____

____

Have either of you been in Therapy before? If yes, with whom, when, for what? ______________________

____

Reason for terminating? ____________ **May I contact your previous therapist(s)?** ___ Yes ___ No

Have you been in couples counseling before? If yes, with whom, when, for what? ____________________

____

Reason for terminating? ____________ **May I contact your previous therapist(s)?** ___ Yes ___ No

HEALTH HISTORY

Do you have any health concerns? ___ Yes ___ No **Explain:** ______________________________

Does your partner have any health concerns? ___ Yes ___ No **Explain:** ______________________

How often do you go to the doctor? ______________________ **Doctor's Name:** __________________

How often does your partner go to the doctor? ______________**Doctor's Name:** __________________

Current Medications & Diagnosis: ________________________________ ___________________

Past Medications: ____

Partner's Current Medications & Diagnosis: ____

Partner's Past Medications: ____

Have either of you been hospitalized? ___ Yes ___ No **Explain:** _________________________________

Do either of you see a Psychiatrist? ___ Yes ___ No **Psychiatrist Name(s):** ____________________

Do either of you have a history of seeing a Psychiatrist? ? ___ Yes ___ No **When?**___________________

May I contact your past or present Psychiatrist(s)? ___ Yes ___ No **Name(s):** ____________________

____**Phone:** ______________________________

How many days a week do you exercise? ___ Never ___ Sometimes ___ 1-2 ___ 3-4 ___ 5-6 ___ Everyday

How many days a week does your partner exercise? ___ Never ___ 1-2 ___ 3-4 ___ 5-6 ___ Everyday

Do you smoke? ___ Yes ___ No **Do you use drugs?** ___ Yes ___ No **Explain:** ______________________

Partner smoke? ___ Yes ___ No **Partner use drugs?** ___ Yes ___ No **Explain:** ____________________

Do you drink alcohol? ___ Yes ___ No **How often?** ___ 1-2x month ___ 1-2x week ___ Most Days ___ Everyday

Partner drink alcohol? ___ Yes ___ No **How often?** ___ 1-2x month ___ 1-2x week ___ Most Days ___ Everyday

Explain: ____

RELATIONSHIP HISTORY

Have either you or your partner struck, physically restrained, used violence against or injured the other person? If yes, when, how often, describe what happened: ______________________________

____

____

Are you monogomous? ___ Yes ___ No **Explain:** ______________________________

Have either of you threatened to separate or divorce? ___ Yes ___ No ______________________________

Has either partner consulted with a lawyer about divorce? ___ Yes ___ No ___ Unsure

Has either partner withdrawn from the relationship? ___ Yes ___ No **Explain:** ______________________________

____

Describe your sexual relationship: ___ Terrible ___ Mostly unpleasant ___ Neutral ___ Mostly pleasant ___ Great

Frequency of Sex: ___ Way too often ___ A bit too often ___About right ___ A bit too seldom ___Way too seldom

What is the relationship's current stress level ___ Very High ___ High ___ Moderate ___ Low ___ Very Low

Do you have family and friends that support you as a couple? ___ Yes ___ No **Explain:** ______________________________

____

Do you share a similar outlook on life? ___ Yes ___ No **Explain:** ______________________________

Put a check mark next to any of the following that apply to you or your partner:

___ Alcoholism ___ Drug Abuse ___ Domestic Violence ___ Sexual Addiction ___ Sexual Abuse ___ Physical Abuse

___ Trauma ___ Mental illness ___ Suicidal Ideation ___ Hopeless ___ Homicidal Ideation ___ Lying ___Pornography

___ Recklessness ___ Legal Issues ___ DWI/DUI ___ Alcohol Abuse ___ Binge Drinking ___ Eating Disorder ___ Stealing

___ Can't Keep a Job ___ Odd behavior ___ Sleep disturbance ___ Aggression ___ Crying Often ___ Compulsions

___ Obsessions ___ Work Too Much ___ Phobic Avoidance ___ Take too many risks ___ Loss of control ___Blackouts

___ Impulsive ___ Procrastination ___ Jealous ___ Secretive ___ Disappears Often ___ Cheating ___ Promiscuous

___ Flirtatious ___ Nervous Tics ___ Unable to concentrate ___ Anxious ___ Depressed ___ Angry ___ Sad

___Withdrawn ___Insomnia ___Overeats ___Gambling ___Irresponsible ___Controlling ___Violence [ ]Spend too much $

___ Loss of Interest in Activities Previously Enjoyed ___ No Friends ___ Served or serving in Armed Forces ___ Other

If you answered yes to any of the above, describe in detail: ______________________________

____

____

Describe the Relationship with your Families: ___Supportive ___Unsupportive ___ Strained ___ Not Speaking ___ Too Involved ___ Controlling ___ Other ____

Family History of Mental Illness? ___ Yes ___ No **Substance/Alcohol Abuse?** ___ Yes ___ No **Explain:** ________

____

Do you have any children together? ___ Yes ___ No **Explain (include names & ages):** ______________

____

Do you have any children with other partners? ___ Yes ___ No **Explain (include names & ages):** ________

____

Are you religious/spiritual? ___ Yes ___ No **Denomination**: ___________________________________

Any shared Hobbies/Interests? ___ Yes ___ No **Explain:** ______________________________________

____

Would you like my certified therapy dog to join us? ___ Yes ___ No ___ Maybe

How did you hear about my services/who referred you? __________________________________

Share anything in the space below that you think would be helpful for me, as your therapist, to know.

____

____

____

I certify that all of the information I provided is accurate to the best of my knowledge. I understand that it is my responsibility to provide accurate and updated information to my therapist at all times.

Signature: ____ **Date**: ____________________

Partner's Signature: ______________________________ ________ **Date**: ____________________