Couple Intake Information

The purpose of the following questionnaire is to help your counselor understand some important things about you and your spouse so that we may help you most effectively. Please complete these forms as fully as possible.

Your Information

Name____ Date____________________
(Last) (First) (Middle)

Address____

City_____________________________________ County___________ ZIP Code________________

Phone (H)______________________ (W)______________________ Other______________________

E-mail ____

Emergency Contact____
(Name) (Address) (Phone)

Birth Date____________________________________ Age__________

Education & Degree (if applicable)____

Name of church you attend (if applicable)____

Occupation_________________________________ Employer____________________________________

Spouse Information

Name____ Date____________________
(Last) (First) (Middle)

Address____

City_____________________________________ County___________ ZIP Code________________

Phone (H)______________________ (W)______________________ Other______________________

E-mail____

Emergency Contact____
(Name) (Address) (Phone)

Birth Date____________________________________ Age__________

Education & Degree (if applicable)____

Name of church you attend (if applicable)____

Occupation_________________________________ Employer____________________________________

Couples Intake Information (continued)

Marital History
Date married _______________________________ Number of years married _____________________________

Your age when married ________________________Spouse's age when married __________________________

Previous marriages (indicate number of years married and any children resulting from that marriage) :

Yourself: ____

Spouse: ____

Please list the names and ages of all who live in your home:

Names Ages Indicate where they live

_________________________________ _______________ ____

_________________________________ _______________ ____

_________________________________ _______________ ____

_________________________________ _______________ ____

Family History

Describe your family's relationship with one another growing up. (Ex: How did your parents get along, how did you and your siblings get along?)

Yourself: ____

____

Spouse: ____

____

Discuss your current relationship with your parents.

Yourself: ____

Spouse: ____

Please list your brothers, sisters, and yourself in birth order starting with the oldest. Give their ages. Be sure to include yourself by indicating "me."

Yourself

Names Ages

____ ________________________

____ ________________________

____ ________________________

____ ________________________

____ ________________________

Couples Intake Information (continued)

Spouse

Names Ages

____ _______________________

____ _______________________

____ _______________________

____ _______________________

____ _______________________

Does someone in your family have a substance abuse problem?

Yourself: ____

Spouse: ____

Has someone in your family ever received counseling or psychiatric diagnosis?

Yourself: ____

Spouse: ____

Have you or a family member ever experienced domestic violence?

Yourself: ____

Spouse: ____

Client History

Referred by____ Address_______________________________

Have you ever received counseling before? Yes_____ No_____

If so, list counselor(s) and dates: ____

Has your spouse ever received counseling before? Yes_____ No_____

If so, list counselor(s) and dates: ____

What was helpful? ____

____

Have you had any major losses or traumatic experiences in your life?

Yourself: ____

Spouse: ____

____

Couples Intake Information (continued)

List any major health problems for which you or your spouse are currently receiving treatment:

Yourself: ____

Spouse: ____

List any medications (including dosages) you or your spouse are currently taking:

Yourself: ____

Spouse: ____

Briefly describe the problem for which you are seeking help:

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