



## Couple Intake Form

**PERSON ONE:**

Today's Date \_\_\_\_\_

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (home) \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Phone (work) \_\_\_\_\_ Email \_\_\_\_\_

Preferred way to be contacted:  Home  Cell  Work  Email  Mail

Can I leave a phone message?  Yes  No Can I send a text?  Yes  No

**Relationship Status:**

- \_\_\_\_\_ Single
- \_\_\_\_\_ Dating
- \_\_\_\_\_ Engaged
- \_\_\_\_\_ Married/Living with Partner
- \_\_\_\_\_ Separated
- \_\_\_\_\_ Divorced
- \_\_\_\_\_ Widowed
- \_\_\_\_\_ Single Parent
- \_\_\_\_\_ Other: \_\_\_\_\_

**Ethnic/Racial Origin:**

- \_\_\_\_\_ Asian / Asian-American
- \_\_\_\_\_ Black / African-American
- \_\_\_\_\_ Caucasian / White / Euro-American
- \_\_\_\_\_ Latino/a / Hispanic (Please specify: \_\_\_\_\_)
- \_\_\_\_\_ Middle Eastern
- \_\_\_\_\_ Native American / Indian
- \_\_\_\_\_ International
- \_\_\_\_\_ Biracial / Multiracial (Please specify: \_\_\_\_\_)
- \_\_\_\_\_ Other: Please specify: \_\_\_\_\_
- \_\_\_\_\_ I would not like to disclose

Age: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Referring Person/Agency: \_\_\_\_\_

**Gender:**

- \_\_\_\_\_ Male
- \_\_\_\_\_ Female
- \_\_\_\_\_ Other: \_\_\_\_\_

**Previous Counseling/Therapy Experiences:**

- \_\_\_\_\_ None
- \_\_\_\_\_ Therapist: (Dates) \_\_\_\_\_
- \_\_\_\_\_ Agency: (Dates) \_\_\_\_\_

**Spiritual / Religious Affiliation:**

- Catholic  Protestant  Muslim  Hindu  Buddhist  Jewish  Atheist  Islamic
- Mormon  Baptist  Episcopalian  Lutheran  Methodist  PCA/PCUSA  Mennonite
- Chinese Traditional  Non-Denominational  Other: \_\_\_\_\_
- I would not like to disclose

Are you currently practicing your religion / spirituality?  Yes  No  I would not like to disclose

Please list any medications you are currently taking and what they treat:

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Please list any other drugs you are currently taking (including recreational):

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Please list any medical issues you are currently receiving treatment for:

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Please provide information about your family:

	Name	Occupation	Alive/Deceased	Age
Parent(s)				
Step-Parent(s)				
Sibling(s)				
Partner/Spouse				
Children				
Other				

In case of emergency:

Local friend/relative (please have one not living with you)	Relationship	Phone No.
1. _____	_____	_____
2. _____	_____	_____

What would you like to accomplish in therapy individually and/or together?

1. \_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_

**PERSON TWO:**

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (home) \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Phone (work) \_\_\_\_\_ Email \_\_\_\_\_

Preferred way to be contacted:  Home  Cell  Work  Email  Mail

Can I leave a phone message?  Yes  No Can I send a text?  Yes  No

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Relationship Status:

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\_\_\_\_\_ Dating  
\_\_\_\_\_ Married/Living with Partner  
\_\_\_\_\_ Separated  
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\_\_\_\_\_ Widowed  
\_\_\_\_\_ Single Parent  
\_\_\_\_\_ Other: \_\_\_\_\_

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\_\_\_\_\_ International  
\_\_\_\_\_ Biracial / Multiracial (Please specify: \_\_\_\_\_)  
\_\_\_\_\_ Other: Please specify: \_\_\_\_\_  
\_\_\_\_\_ I would not like to disclose

Age: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Referring Person/Agency: \_\_\_\_\_

Gender:

\_\_\_\_\_ Male  
\_\_\_\_\_ Female  
\_\_\_\_\_ Other: \_\_\_\_\_

Previous Counseling/Therapy Experiences:

\_\_\_\_\_ None  
\_\_\_\_\_ Therapist: (Dates) \_\_\_\_\_  
\_\_\_\_\_ Agency: (Dates) \_\_\_\_\_

Spiritual / Religious Affiliation:

Catholic  Protestant  Muslim  Hindu  Buddhist  Jewish  Atheist  Islamic  
 Mormon  Baptist  Episcopalian  Lutheran  Methodist  PCA/PCUSA  Mennonite  
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Other				

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1. _____	_____	_____
2. _____	_____	_____

What would you like to accomplish in therapy individually and/or together?

1. \_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_

Any other relevant information I should know?

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