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Well CENTERED

Couples Counseling Intake Form

Personal Information

Today's Date: _____

Last Name: _____ First Name: _____ M.I.:_____

Age: _____ Date of Birth: _____

Last Name: _____ First Name: _____ M.I.:_____

Age: _____ Date of Birth: _____

Street Address:

_____

City: _____ State: _____ Zip code: _____

Secondary address if living separately:

_____

City: _____ State: _____ Zip code: _____

Ok to send mail? _____

Home phone: _____ Ok to leave a message? _____

Cell phone: _____ Ok to leave a message? _____

Work phone: _____ Ok to leave a message? _____

Name of emergency contact: _____ Relationship to you: _____

Home Phone: _____ Cell/Work Phone: _____

Referral Source (how you heard about Well CENTERED):

_____

Health Information

Please answer the following questions using: 5 -Excellent, 4 -Good, 3 - Average, 2 - Poor, 1 - Failing
How would you currently rate your physical health? _____/_____
How would you currently rate your mental health? _____/_____
How would you currently rate your spiritual health? _____/_____ (if does not apply to you, please use N/A)
Please list current symptoms (reason you are here) and circle those you currently find most bothersome in your relationship:

_____

_____

_____

_____

Medical Information

Do you now have, or have you had in the past, any of the following? Circle all that apply and indicate who has had the issue:

Asthma
Allergies
Headaches
Brain Injury
Epilepsy Seizures
Digestive Disorders
Cancer
Diabetes
Breathing Problems
Immune System Problems
Heart Disease
High Blood Pressure
Vision Problems
Hearing Problems
Arthritis

Disturbed eating patterns
Urinary Disorders
Tuberculosis
Thyroid Disorder
Multiple Sclerosis
Chronic Fatigue Syndrome
Fibromyalgia Pregnancy (how many)_____
Miscarriage (how many)_____
Abortion (how many)_____
Sexually Transmitted Disease
Sleep Disorder
Serious Accident Surgery
Other

Name of Primary Care Physician: _____ Physician Phone #: _____
Address:_____

Please list any prescription medications either of you are currently taking:

_____

_____

_____

Please list any over the counter medications, vitamins, or herbal supplements either of you are currently taking:

_____

_____

_____

Do either of you currently exercise? _____/_____
If yes, please indicate how many times per week: _____/_____

Please indicate substances either of you have recently or currently use (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used. Please write your name next to the substance if just one of you participates in use.

Substance	Current	Amount	Frequency	Age	Past	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						

Have either of you ever believed substance use was a problem in the relationship? If yes, please describe...

_____

_____

_____

Have either of you ever participated in drug and alcohol treatment? _____
If yes, please list type, length, dates, and age at time you received these services:

_____

_____

Do you currently or have either of you ever attended Alcoholics or Narcotics Anonymous? _____
If yes, please list length of time sober and number of meetings you attend per week:

_____

Mental Health Information

Have you ever been in couples counseling/therapy before? _____
If yes, did you find it helpful or effective?

_____

_____

Are either of you currently receiving individual mental health services? _____
If yes, please list name of practitioner and type of services you are receiving:

_____

_____

Have either of you ever been hospitalized for mental health concerns? _____ If yes, list date(s) and length of stay:

_____

_____

Have either of you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed:

_____

_____

Has anyone in your family ever been diagnosed with a mental illness? If yes, please list relationship(s) and illness(es):

_____

_____

Has anyone in the relationship ever or is anyone currently engaging in self harm?
Currently: _____/_____ Past: _____/_____

Has anyone in the relationship ever or is anyone currently contemplating suicide?
Currently: _____/_____ Past: _____/_____
Has anyone in the relationship ever attempted suicide? _____
If yes please list who and approximate dates/age at time of attempt:

_____

_____

Do either of you currently or have you ever had trouble sleeping? ____ If yes, please describe:

_____

_____

Do either of you currently or have you ever had problems with eating or with food? ____ If yes, please describe:

_____

_____

_____

Spiritual Information

Have you ever or do you currently engage in a faith practice as a couple or individually? ____ If yes please describe:

_____

_____

_____

Do you currently belong to a faith community (church, synagogue, temple, religious order, etc.?

_____

If yes, please describe your current level of connection and involvement:

_____

_____

_____

Do you want to incorporate your faith/spirituality into the counseling process?

_____

_____

Relationship Information

Length of time you have known each other:_____

Length of time you have been together: _____Do you currently live together?_____

Any previous marriages? _____

Are you currently contemplating divorce? _____

Do you have children? _____ If yes, please list below and indicate any special circumstances

Name_____ Age_____ Lives with you_____

Name_____ Age_____ Lives with you_____

Name_____ Age_____ Lives with you_____

Name_____ Age_____ Lives with you_____

Other persons living in your household and your relationship to them:

_____

_____

Please indicate if either of you have experienced any of the following.

Event	Partner 1	Partner 2	While in this Relationship? y/n
Emotional Abuse			
Legal Problems			
Physical Abuse			
Frequent/Multiple Moves			
Sexual Abuse			
Homelessness			
Domestic			
Violence			
Financial Problems			
Neglect			
Lived over-seas			
Substance Abuse			
Military member			
Serious Illness			
Discrimination			
Accident or Injury			