Couple Intake Document

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Client Name _____ **Birth date** _____

Address _____ **Age** _____

City, State, Zip _____ **Gender: Female Male**

Relationship Status: Single Married Domestic Partner Separated Divorced Widowed

Primary Care Physician _____ **(___)** _____
Phone

Your Phone # (___) _____ **(___)** _____
Home: OK to contact there? Y N Work: OK to contact there? Y N
OK to leave detailed msg.? Y N OK to leave detailed msg.? Y N

Cell#: (_____)_____

Email: _____

Please list all persons living in the household:

Name	Age	Relationship	Characteristics of interactions with identified client or family. (ex. Fight, get along well, ignores, blames, etc.)

1. Please describe your reason(s) for seeking treatment currently. If there is an event which triggered your decision to seek treatment now, please list the event.

_____

_____

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2. Please indicate how the issue for which you are seeking treatment are affecting the following areas of your life:

Use the following scale:
1-5 (No effect, little effect, some effect, much effect, severe effect and NA)

____Marriage/Relationship
____Family
____Job/School performance
____Friendships
____Financial Situation
____Physical health
____Anxiety level/nerves
____Mood
____Eating habits
____Sleeping habits
____Sexual functioning
____Alcohol/Drug usage
____Ability to concentrate
____Ability to control temper
____Suicidal thoughts/behavior
____Self-mutilation

3. What result(s) do you expect from treatment?

_____

_____

_____

4. Medications: (please list all psychoactive medications you have used)

Med./Dose	Past/ current	Effectiveness/problems	Prescribing physician and phone

5. Please list any over the counter medications you take: _____

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6. **Please describe your use of the following substances:**

Alcohol: __No use __Past only __Minimal __Occasional __Often __Problematic

Nicotine: __No use __Past only __Minimal __Occasional __Often __Problematic

Marijuana: __No use __Past only __Minimal __Occasional __Often __Problematic

Cocaine: __No use __Past only __Minimal __Occasional __Often __Problematic

Meth: __No use __Past only __Minimal __Occasional __Often __Problematic

Heroin: __No use __Past only __Minimal __Occasional __Often __Problematic

Rx abuse: __No use __Past only __Minimal __Occasional __Often __Problematic

7. **Are there any cultural, ethnic or religious factors or needs related to treatment? No Yes:**

_____

8. **Please list your strengths and resources that positively impact your coping and ability to overcome adversity:**_____

_____

9. **How long have the two of you been together?** _____

10. **List any significant events in your relationship that have created emotional damage:**

_____

_____

_____

11. **How committed are you to saving the relationship? 1 = minimal to a level of 5 = extremely committed:** _____.

12. **How committed to saving the relationship do YOU believe your partner is?** _____.

PLEASE LIST PREVIOUS OR CURRENT THERAPIES AND/OR COUNSELING THAT YOU HAVE RECEIVED.

THERAPIST NAME/PHONE	TREATMENT ISSUE	OUTCOME/ EFFECTIVENESS	DATES

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ARE THERE AREAS OF CONCERN THAT WERE NOT COVERED IN THIS QUESTIONNAIRE THAT YOU FEEL ARE IMPORTANT TO BE AWARE OF SUCH AS FAMILY ISSUES, RECENT SIGNIFICANT EVENTS, ETC.?

EMERGENCY PROCEDURES

If you need to contact me, leave a message on my voicemail and your call will be returned. If an emergency situation arises, don't hesitate to call. I will return your call. Please use this for true emergencies and know that there may be a charge for lengthy telephone consultations. You may also always call 911 and speak to your local police.

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out mental health examinations, treatment, and/or diagnostic procedures, which now or during my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I understand that the therapist or client(s) can terminate therapy at any time by giving notice personally, in writing or over the phone.

LIMITATION ON CONFIDENTIALITY WHEN PROVIDING THERAPY TO FAMILIES

When treating a couple, I consider the couple (the treatment unit) to be the 'patient/client'. For instance, if there is a request for treatment records for either or both members of the couple, I will seek authorization for release of information from both members. During therapy, I may see a smaller part of the treatment unit for one or more sessions. This should be viewed as part of the treatment being provided to the couple unless otherwise indicated. However, I may need to share information learned in an individual session with your partner. I will use my best judgment as to whether, when, and to what extent I will make disclosures to your partner and will also, if appropriate, first give the individual being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This policy is intended to allow me to continue to treat the couple by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple being treated. For example, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple. If I am not free to exercise my clinical judgment regarding the need to bring this information to the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple. This policy is intended to prevent the need for such a termination.

Signing below indicates you have had a chance to read and ask questions about this policy and that you are in full agreement with the policy.

_____

Signature **Date**