COUPLES/FAMILY COUNSELING INTAKE SHEET

Who referred you to our center? ____
May we contact them? ____ Yes ____ No

CLIENT INFORMATION

Husband____
Last Name First Name MI Nickname
Address ____
Street City State Zip
Date of Birth ________ Age _____ Occupation ______________Hours/Week _____

Contact phone:____
May we leave messages on this phone? ____Yes ____No
May I send text messages to this phone? ___Yes ___ No
Email ____

Wife____
Last Name First Name MI Nickname
Address ____
Street City State Zip

Date of Birth ________ Age _____ Occupation ______________Hours/Week _____

Contact phone:____
May we leave messages on this phone? ____Yes ____No
May I send text messages to this phone? ___Yes ___ No
Email ____

FAMILY INFORMATION

Parent's Current Marital Status:
___ Never Married ___ Married ___ Engaged ___ Divorced ___ Separated ___Remarried

Date of Marriage (if applicable) ____
Date of Divorce (if applicable) ___________ Date of Death (if applicable) ___________

Husband Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____________________
Wife Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____________________

Previous Marital History (if applicable):

For office use:
Therapist: ____________________________
Diagnostic code: ________________________
Date of first session: ___________ fee ________
Insurance Carrier: _________________ Y or N

Husband:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
______________________	_________________	___________________
______________________	_________________	___________________

Wife:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
______________________	_________________	___________________
______________________	_________________	___________________

Names of other family members (Please indicate which members reside in the household)

__________________________ Age ____ Gender ____ Relationship ____________________
__________________________ Age ____ Gender ____ Relationship ____________________
__________________________ Age ____ Gender ____ Relationship ____________________
__________________________ Age ____ Gender ____ Relationship ____________________

Please list a history of mental health issues in husband's family: __________________________

Please list a history of mental health issues in wife's family: ______________________________

PERSONAL INFORMATION

Please answer the following for each person in counseling by marking Mark "H" for Husband and "W" for Wife and "1", "2", "3", etc… for children in birth order.

How would you rate your health? ____
How many hours do you sleep each night? ____
How would you rate your diet?
___ Very Healthy ___ Healthy ___ Average ___ Needs Improvement ___ Poor
Do you have addictive/abusive issues with: ___ Alcohol ___ Illegal Drugs ___ Prescriptions
___ Sex ___ Pornography ___ Gambling ___ Gaming ___ Other: ________________
Has your appetite or weight changed lately? ____
Are you currently on medication? ____ Yes ____ No
If so, please complete the following:

Medication	Dosage	Physician	Purpose
______________________	________	____________	____________________________
______________________	________	____________	____________________________
______________________	________	____________	____________________________
______________________	________	____________	____________________________
______________________	________	____________	____________________________
______________________	________	____________	____________________________

Have any of the family members ever experienced mental, physical, emotion, or sexual abuse or neglect? _____ Yes _____No
If, yes, please describe: ____

How have these issues been addressed?

Are any of the family members adopted?
Do you currently attend a church? ____ Yes ____ No
If yes, what is the name of the church?
Would you like spiritual matters to be part of your counseling? ____ Yes ____ No

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience.

What efforts have you or already made to address these concerns?

Have you been in counseling before? ____ Yes ____ No
If so, for each incidence you remember, please complete the following:

1. Who was the counselor?
   What was the problem?
   How many sessions over what period of time?
   What were the results?

2. Who was the counselor?
   What was the problem?
   How many sessions over what period of time?
   What were the results?

3. Who was the counselor?
   What was the problem?
   How many sessions over what period of time?
   What were the results?

Thoughts and Behaviors

Please answer the following for each person in counseling by marking Mark "H" for Husband and "W" for Wife and "1", "2", "3", etc… for children in birth order.

Please check how often the following thoughts occur to you:

#	Thought	Never	Rarely	Sometimes	Frequently
1.	Life is hopeless.	____ Never	____ Rarely	____ Sometimes	____ Frequently
2.	I am lonely.	____ Never	____ Rarely	____ Sometimes	____ Frequently
3.	No one cares about me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
4.	I am a failure.	____ Never	____ Rarely	____ Sometimes	____ Frequently
5.	Most people don't like me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
6.	I want to die.	____ Never	____ Rarely	____ Sometimes	____ Frequently
7.	I want to hurt someone.	____ Never	____ Rarely	____ Sometimes	____ Frequently
8.	I am so stupid.	____ Never	____ Rarely	____ Sometimes	____ Frequently
9.	I am going crazy.	____ Never	____ Rarely	____ Sometimes	____ Frequently
10.	I can't concentrate.	____ Never	____ Rarely	____ Sometimes	____ Frequently
11.	I am so depressed.	____ Never	____ Rarely	____ Sometimes	____ Frequently
12.	God is disappointed in me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
13.	I can't be forgiven.	____ Never	____ Rarely	____ Sometimes	____ Frequently
14.	Why am I so different?	____ Never	____ Rarely	____ Sometimes	____ Frequently
15.	I can't do anything right.	____ Never	____ Rarely	____ Sometimes	____ Frequently
16.	People hear my thoughts.	____ Never	____ Rarely	____ Sometimes	____ Frequently
17.	I have no emotions.	____ Never	____ Rarely	____ Sometimes	____ Frequently
18.	Someone is watching me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
19.	I hear voices in my head.	____ Never	____ Rarely	____ Sometimes	____ Frequently
20.	I am out of control.	____ Never	____ Rarely	____ Sometimes	____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

Symptom	Rating	Symptom	Rating
Excessive anger, easily frustrated	____	Hyperactivity	____
Mood swings (depression-manic)	____	Change or loss of friends	____
Excessive guilt or shame	____	Sexual problems	____
Loss of energy	____	Self-mutilation, cutting	____
Loss of interest in activities	____	Excessive stress	____
Suicidal thoughts	____	Anxiety or excessive fears	____
Suicide attempts (how many)	____	Learning disabilities	____
Lying	____	Work or school related problems	____
Manipulation	____	Hallucinations, delusions, thought distortions	____
Poor impulse control	____	Obsessive thoughts &/or compulsive behaviors	____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

____
____
____
____
____
____
____
____
____
____

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name ____

Address ____

Home Phone ______________________________ Cell Phone ______________________________