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Couples Intake Questionnaire

Today's date: _____/_____/_____

1. Your name: _____
   (First) (Middle) (Last)
2. Address: _____
3. Mailing address (if different from above): _____
   _____
4. Phone number: Cell:_____ Home: _____ Work: _____
   Which number(s) may I use to contact you? (please circle) Cell Home Work
   Which number(s) may I leave a voice message? (please circle) Cell Home Work
5. Your age:_____ Your date of birth: _____/_____/_____ Your gender: M F
6. Your relationship status: (please circle) Single Partnered Married
   Separated Divorced Widowed
   Dating
7. If married/partnered, how many years?_____ Spouse/Partner's age: _____
8. If remarried, how many times? _____
9. Your living situation (alone, roommate(s), spouse, partner, parents, children): _____
   _____
10. Your occupation:_____
    Employment status: (please circle) Full-time Part-time Unemployed Student
    Your annual income: _____
11. Your spouse's/partner's occupation: _____
    Employment status: (please circle) Full-time Part-time Unemployed Student
    Spouse's/Partner's annual income: _____
12. Using the numbers below, indicate the highest level of school completed by you and your spouse/partner, if married/partnered. You:_____ Your Spouse/Partner: _____

K 1 2 3 4 5	6 7 8	9 10 11 12	13 14 15 16	17 18 19 20 21
Elementary School	Middle School	High School	College	Graduate School

13. Family members in household (Name) Relationship to you Age Date of Birth

_____	_____	____	_____/_____/_____
_____	_____	____	_____/_____/_____
_____	_____	____	_____/_____/_____
_____	_____	____	_____/_____/_____
_____	_____	____	_____/_____/_____
_____	_____	____	_____/_____/_____

14. Number of children living with you: _____ Of these, how many are step-children?_____

15. Number of children not living with you:_____ Of these, how many are step-children? _____

16. Type of therapy you are seeking? (please circle) Individual Couple Family Child

17. Have you ever been in therapy or received counseling? (please circle) Yes No
If so, how many times?_____ When? _____
For how long?_____ Why did it end?_____

18. Have you ever been prescribed medication for emotional/psychiatric issues? (please circle)
Yes * No * If yes, please list current medications below:

Medication	Prescribing Physician	Reason?	How long taken?

19. Have you ever been hospitalized for emotional, psychiatric, or addiction problems?
(please circle) Yes No
Number of times: _____ Length of time of last hospitalization: _____
Reason for last hospitalization: _____

20. Have you ever attempted suicide? (please circle) Yes No
Number of times: ____ Approximate date(s) of attempt(s):_____

21. Name of Emergency Contact: _____Phone:_____

22. Person or agency that referred you: _____

23. If no referral, how did you hear about me?_____