

Couples Counseling Intake Form (to be submitted individually)

GENERAL

Name _____ Date of birth _____

Home address (city & zip) _____

Business address (city & zip) _____

Home phone _____ May I leave a message? _____

Work/cell phone _____ May I leave a message? _____

E-mail _____ May I contact you by email? _____

Employer/school _____ Occupation/studying _____

Annual Income _____ Social Security No. _____

Emergency contact _____ Phone _____ Relationship _____

Educational background _____

Learning disabilities _____

Ethnicity _____ Past religious affiliation (if any) _____

Present affiliation/identification (if any) _____

Previous counseling and psychotherapy (dates and names of therapists)

MEDICAL

Name of physician _____ Date of last exam _____

Medical problems or illness _____

Medications _____

FAMILY INFORMATION

Name of partner _____

If living together, how long? _____ If married, how long? _____

Significant partner status (please circle) Single Engaged Married Divorced
Separated Living together Remarried Widowed



Name of significant partner _____

Children from this relationship

Name _____ Gender _____ Age _____

Name _____ Gender _____ Age _____

If previously married/partnered, please indicate

Name of former spouse	Years married	Date marriage ended	Reason marriage ended
_____	_____	_____	_____
_____	_____	_____	_____

Children from previous relationship

Name _____ Gender _____ Age _____

Name _____ Gender _____ Age _____

Issues I would be interested in addressing in couples counseling:

Other comments:
