**Rebuilding Lives Counseling and Consulting**

**Couples Intake Form**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Partner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age: \_\_\_\_\_\_\_\_ Partner’s Age:\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Partner’s Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Partner’s Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_**

**Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Partner’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been to couple’s counseling before? If so,**

**Name of practice if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long ago?\_\_\_\_\_\_\_\_\_\_ Length of time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was the problem treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was goal accomplished? Y/N If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you or your partner ever engaged in individual therapy? Y/N**

**If yes, when and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Have you or your partner been diagnosed with a mental illness? Y/N If so, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you or your partner see a psychiatrist? Y/N If so, why? \_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Please list all medication taking (Client):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **MD Prescribing Medication** | **Physician Number** | **Condition** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Please list all medication taking (Partner):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **MD Prescribing Medication** | **Physician Number** | **Condition** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Current Relationship Status (circle which one applies):**

Married Separated Divorced Dating

**How long have you been in this relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been married before? If so, how many times?**

**Client: Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Partner: Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information Regarding Children:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age** | **M/F** | **Custody Y/N** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**What brings you and your partner to therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**How concerned are you and your partner about the problem (circle the one that applies):**

***Level of Concern***

□ No concern □ Little concern □ Moderate concern □ Serious concern □ Very serious concern

***Frequency***

□ No occurrence □ Occurs rarely □ Occurs sometimes □ Occurs frequently □ Occurs nearly always

**Partner:**

***Level of Concern***

□ No concern □ Little concern □ Moderate concern □ Serious concern □ Very serious concern

***Frequency***

□ No occurrence □ Occurs rarely □ Occurs sometimes □ Occurs frequently □ Occurs nearly always

**What have you and your partner tried to deal with challenges?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Partner:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**What do you and your partner hope to get out of counseling?**

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**What are your strengths as a couple? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**What are your weakness as a couple? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you or your partner have any alcohol or drug problems? If so, answer following questions below:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Alcohol/Drugs** | **Use****Y/N** | **Frequency Of Use****Days Per Week** | **Amount Per Use** |
| **Beer** |  | **1 2 3 4 5 6 7** |  |
| **Wine** |  | **1 2 3 4 5 6 7** |  |
| **Hard Liquor** |  | **1 2 3 4 5 6 7** |  |
| **Marijuana** |  | **1 2 3 4 5 6 7** |  |
| **Cocaine** |  | **1 2 3 4 5 6 7** |  |
| **Amphetamines** |  | **1 2 3 4 5 6 7** |  |
| **Narcotics** |  | **1 2 3 4 5 6 7** |  |
| **Diet Pills/Pills** |  | **1 2 3 4 5 6 7** |  |
| **Other** |  | **1 2 3 4 5 6 7** |  |

**Partner:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Alcohol/Drugs** | **Use****Y/N** | **Frequency Of Use****Days Per Week** | **Amount Per Use** |
| **Beer** |  | **1 2 3 4 5 6 7** |  |
| **Wine** |  | **1 2 3 4 5 6 7** |  |
| **Hard Liquor** |  | **1 2 3 4 5 6 7** |  |
| **Marijuana** |  | **1 2 3 4 5 6 7** |  |
| **Cocaine** |  | **1 2 3 4 5 6 7** |  |
| **Amphetamines** |  | **1 2 3 4 5 6 7** |  |
| **Narcotics** |  | **1 2 3 4 5 6 7** |  |
| **Diet Pills/Pills** |  | **1 2 3 4 5 6 7** |  |
| **Other** |  | **1 2 3 4 5 6 7** |  |

**Are there any legal problems as a result of alcohol or drug use for you or your partner? Y/N If so, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you or your spouse have any medical problems? Y/N**

**Partner? Y/N If so, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Setting Your Goal:**

1. **Team Work**
2. **Take Responsibility for your own actions**
3. **Be respectful**
4. **Positive communication**
5. **Manage your own stress**

**What are 2-3 goals for your relationship?**

**1.**

**2.**

**3.**

**How will we you what you are doing is working (what will life look like in your relationship from a behavior perspective)?**

**1.**

**2.**

**3.**