# COUPLE INTAKE FORM

The information you provide will be used to plan your treatment and is held in strict confidence. You may leave any item blank if you don't feel comfortable providing an answer to at this time. ***You will need to print two copies, one for each partner.***

**Marital Status:** ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name: ______________________________________________
Last First Middle

Birth Date:_______/___________/________ Age:____________ Gender: ______________

Address: ______________________________________________
Number and Street

City:________________________________ Province: ________________________ Postal Code:_______________

**If Separated, please provide secondary address:**

Address: ______________________________________________
Number and Street

City:________________________________ Province: ________________________ Postal Code:_______________

**Contact Information:**

Home Phone: ___________________________ May we leave a message? ☐Yes ☐ No

Mobile Phone:__________________________ May we leave a message? ☐ Yes ☐ No

Email: __________________________________________________ May we leave a message? ☐ Yes ☐ No

Occupation:____________________________________________________________

**EMERGENCY CONTACT INFORMATION (please provide an alternate to your partner):**

Name: _____________________________ Relationship: ________________________ Phone:______________

**FAMILY BACKGROUND:**
Please list the members of your current family, including ages, occupations and any comments about them or comments about your relationship with them:

| Name | Relationship | Age | Occupation | Comments |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Extended Family**: Please list members of your extended family that are key figures in your life (eg. Siblings, parents, grandparents).

| Name | Relationship | Age | Occupation | Comments |
|---|---|---|---|---|
| ____________________ | _________________ | ______ | _________________ | _______________________ |
| ____________________ | _________________ | ______ | _________________ | _______________________ |
| ____________________ | _________________ | ______ | _________________ | _______________________ |

Please check and explain any past, present or impending family issues (Please indicate which partner(s) impacted):

☐ Deaths________________________________________ ☐ Job Loss__________________________________

☐ Financial Crisis________________________________ ☐ Injury / Illness____________________________

☐ Abuse_________________________________________ ☐ Other_____________________________________

**MEDICAL AND HEALTH BACKGROUND:**

Are you currently having thoughts about ending your life or wanting to die? ☐Yes ☐ No

Have you had thoughts about ending your life or wanting to die in the past 3 months? ☐Yes ☐ No

Have you ever attempted to kill or harm yourself in the past? ☐Yes ☐ No

Are you currently having thoughts about wanting hurt or harm somebody else? ☐Yes ☐ No

Are you currently seeing another psychologist, psychiatrist, or therapist? ☐Yes ☐ No

Have you ever seen a psychologist, psychiatrist, or therapist in the past? ☐Yes ☐ No

Have you ever been a victim of rape or received unwanted sexual contact? ☐Yes ☐ No

Have you ever been exposed to physical abuse, emotional abuse, or other trauma? ☐Yes ☐ No

Have you ever witnessed a horrific or terrifying experience (e.g. death) ? ☐Yes ☐ No

**Has anyone in your family ever had:**

Psychiatric Problems: (Depression, Anxiety, Psychosis, Compulsion, Eating Disorder) ☐Yes ☐ No

Unhealthy alcohol or drug use: ☐Yes ☐ No

An attempted or completed suicide: ☐Yes ☐ No

Do you have any current medical problems? ☐Yes ☐ No

(If yes, please provide details)

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Are you currently taking any medications? ☐Yes ☐ No
(If yes, please provide details)

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Have you been hospitalized or treated for serious medical problems in the past year? ☐Yes ☐ No

Who is our regular health care provider? ___________________________________ Phone: __________________
(We will not contact this person without your authorization except in case of emergency)

Are you having trouble with your sleep? ☐Yes ☐ No

☐Difficulty falling asleep ☐Sleeping too much ☐Waking up during the night
☐Disturbing dreams ☐Sleeping too little ☐Not feeling refreshed

Are you having any difficulties with your appetite or eating habits? ☐Yes ☐ No

☐Eating less ☐Eating more ☐Restricting
☐Binging or out-of-control ☐Diminished appetite

Do you currently drink alcohol? ☐Yes ☐ No
Have you ever had a problem with alcohol? ☐Yes ☐ No
Do you currently use drugs? ☐Yes ☐ No
Have you ever had a problem with drugs? ☐Yes ☐ No

How many times per week do you exercise? _________________

What form of exercise do you do? ____________________________________________________________________

How do you relax? ______________________________________________________________________________

**STRENGTHS AND LIKES:**

Which areas of your life are going well?

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Favorite hobbies and activities:

______________________________________________________________________________________________

______________________________________________________________________________________________

**PROBLEM DESCRIPTION:**

Briefly describe the problem(s) for which you are seeking help:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

How long have you been dealing with the problem(s)? ______________________________________________________

How has your relationships, work, or sense of well being been affected by the problem(s)?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

How have you tried to fix or cope with the problem(s)?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

What are your treatment goals for the problem(s)?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Is there anything else about you that I should know in order to understand you or your problem accurately?