CMB COUNSELING LLC **COUPLES INTAKE FORM**

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The following questionnaire is designed to gather initial intake information that is needed to open your case and to gather initial assessment information regarding your treatment needs. Please complete this form to the best of your ability. If you have any questions regarding the contents of this questionnaire or are not comfortable answering a particular question, please leave the item blank or ask for assistance. Thank you!

Today's Date: ______________________

Client Name: ____ Age: _______________

Spouse/Partner Name: ____ Age: _______________

Address of Primary Residence:
____
____
____

Spouse/Partner's Address (if different)
____
____
____

Home Phone: _______________________________
May I leave a message? ___Yes ____No

Cell Phone: _________________________________
May I leave a voice/text message: ____Yes ____No

Email:____

Home Phone: _______________________________
May I leave a message? ___Yes ____No

Cell Phone: _______________________________
May I leave a voice/text message: ____Yes ____No

Email: _____________________________________

Please list names and ages of other family members currently living in the home:
____ ____
____ ____
____ ____

Who referred you? ____

Relationship Status: (please check all that apply)

_____ Married _____Living together _____Divorced _____Dating
_____Separated _____Living apart _____In process of divorce _____Engaged

General Relationship History:

How long have you and your spouse/partner been together? ____

If married, how many years? _______________________ How long did you date prior to marriage? _____________

How did you meet your spouse/partner? ____
____
____

How would you describe your relationship? ____
____
____

How would your spouse/partner describe your relationship? ____
____
____ (over)

Reason for seeking couples therapy at this time:

1. What is the problem(s) that led you to decide to come to couples therapy? How long has it been going on?

2. How is this relationship issue currently affecting other aspects of your life (i.e. work, family, parenting, etc.)?

3. What things have you tried to improve this issue? Did you experience any amount of success? Please explain.

4. What do you hope to accomplish through counseling?

5. How will you know that your relationship has improved?

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6. What are your biggest strengths as a couple?

(over)

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship:

1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does:

____
____
____
____

Have you ever received couples counseling related to any of the previously mentioned problems? _____ Yes _____ No
If yes:
Name of therapist/agency: ____
Length of treatment: ____
Outcome:____

Have either you or your partner/spouse been, or currently are, in individual counseling? _______ Yes _______No
If yes, please give a brief summary of concerns addressed:

____
____
____
____

Education and Employment

Highest level of education received: ____

Occupation:______________________________________ Name of Employer: _______________________________

Are you currently experiencing difficulties with job performance? If yes, please explain:

____
____
____
____

Spouse/Partner’s highest level of education received: _______________________________________

Spouse/Partner’s Occupation: ________________________ Name of employer: _______________________________

Is your spouse/partner currently experiencing difficulties with job performance? If yes, please explain:

____
____
____
____

(over)

Family Mental Health Background

*Please answer the following questions as related to both yourself and your spouse/partner's family background.

Have you or anyone in your family received mental health services before?_______________________________________

If yes: Who received services? ____

Who provided these services? ____

For how long did you and/or your family members participate in mental health services?___________________________

What issue(s) was the focus of treatment at that time?

How would you describe the experience you and/or your family members have had with mental health services (i.e. positive, helpful, not helpful)

Is a psychiatrist currently treating you or any of your family members? If yes, please explain:

Have you or anyone in your family ever been hospitalized for mental health reasons? If yes, please explain:

Family Medical Background

Have you or anyone in your family ever been diagnosed with a serious medical condition? Please describe:

Are you or anyone in your family currently experiencing any medical/physical symptoms that are related to a mental, emotional, or stress-related condition? Please describe:

(over)

Current or Past Family Stressors

Is there a history of addiction in your family? Please describe:

Is there a history of abuse or violence in your family? Please describe:

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Additional Information

Is there any additional information that you feel is important to provide at this time?

Thank you for your time and attention in completing this form.