Couples Intake Assessment Form

Please provide the following information and answer the questions below.

Please note: Information you provide here is protected as confidential information. You will be asked to talk about your answers in sessions but your partner will not be shown this form. Thank you for completing this form.

GENERAL INFORMATION Today's Date: _____

First Name: Middle initial: Last Name:	Partners Name:
Birthdate: Age:	Gender: [ ] Male [ ] Female
Street Address:	City: State: Zip:
Home Phone:	May we leave a message [ ]Yes [ ] No
Cell Phone:	May we leave a message [ ]Yes [ ] No
Email Address:	
*Please note: Email correspondence is not considered to be a confidential medium of communication.	
Referred by (if any):	

Emergency Contact:

Name: _____ Relationship: _____ Phone#: _____

Cultural Consideration: _____ Religion/spiritual involvement: _____

Do you attend services regularly? _____

Do you find your religious involvement to be helpful or stressful? Please explain: _____

_____

Education: High School: _____ Year Graduated: _____
(Where) (Last grade completed)

Post High School Education: (college/trade school)_____

Degree or Certification: _____

Is or was school performance a concern for you? _____

If yes, explain: (Special education classes? Behavior concerns?) _____

Employment:

Are you currently employed? Yes____ No_____ Name of Employer: _____

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

If unemployed, who was your last employer_____

Employment end date: _____ Reason you left this employer: _____

Current Symptoms Checklist:

☐ Depressed mood ☐ Racing thoughts ☐ Excessive worry ☐ Excessive guilt ☐ Increased irritability ☐ Feeling hopeless/worthless ☐ Impulsivity ☐ Anxiety Attacks ☐ Fatigue ☐ Crying spells ☐ Sleep pattern disturbance ☐ Increase risky behavior ☐ Avoidance ☐ Hallucinations ☐ Increased libido ☐ Decreased libido ☐ Change in appetite ☐Loss of interest/Unable to enjoy activities ☐ Concentration/forgetfulness ☐ Suspiciousness ☐Excessive energy

What are the problem(s) for which you are seeking help? _____

_____

What significant life changes or stressful events have you experienced recently? _____

_____

Abuse/Trauma History Have you experienced physical, sexual or emotional abuse? Yes___ No___

If yes, explain: _____

_____

Suicide Risk Assessment: Have you ever had feelings or thoughts that you didn't want to live? Yes _____ No _____

*If YES, please answer the questions below. If NO, please skip to the next section.

Do you currently feel that you don't want to live? Yes ____ No _____

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

What has helped make it better in the past? _____

Have you ever thought about how you would kill yourself? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? Yes _____ No _____ If yes, please explain. _____

Medical History:

Allergies: _____

Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, check this box ☐)

Medication Name: _____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Please identify any medical history including chronic conditions, surgeries and hospitalizations. No medical concerns, write none: _____

_____

_____

Exercise Level: Do you exercise regularly? Yes ____ No ____ If yes, how many days a week do you get exercise? _____

What kind of exercise do you do? _____

Personal and Family Medical History: Is there any additional personal medical history? Yes ____ No ____

If yes, please explain: _____

When your mother was pregnant with you, were there any complications during pregnancy/birth? _____

_____

Please identify hereditary concerns and medical history of family members:_____

_____

Do you have any sexuality or sexual orientation concerns? Yes ____ No ____

If yes explain: _____

For women only:
Date of last menstrual period _____/_____/_____ Date and place of last physical exam: _____/_____/_____

Are you currently pregnant or do you think you might be pregnant? Yes ____ No ____

Are you planning to get pregnant in the near future? Yes ____ No ____

Birth control method:_____ How many times have you been pregnant? _____

How many pregnancies resulted in: Live births: _____ Miscarriage: _____ Abortion: _____

Tobacco, caffeine and substance use:

How many caffeinated beverages do you drink per day (coffee, tea, soda pop, energy drinks): _____

Explain _____

Do you use tobacco: Yes ____ No ____ If yes, explain _____

Alcohol use:

Daily _____ 2-3 times a week _____ once a week_____ once a month _____ casually _____ never _____

How many drinks do you have per setting? _____

Explain: _____

Do you use any recreational substances not prescribed to you by a doctor: Yes ____ No ____

Explain: _____

History of substance abuse: Yes ____ No ____ Explain: _____

Family history of substance abuse: Yes ____ No ____ Explain: _____

Past Psychiatric History: Outpatient treatment Yes ____ No ____

If yes, Please describe when, by whom, and nature of treatment. Reason/ Dates / Treated By Whom: _____

_____

Psychiatric Hospitalization Yes ____ No ____

If yes, describe for what reason, when and where. Reason/ Date / Hospitalized Where: _____

_____

Psychiatric Medications:

Please indicate if you are currently taking or have taken any medication due to psychiatric concerns: _____

_____

Family members that are currently receiving or have previously received psychiatric treatment: _____

_____

Military: Have you served in the military? Yes ____ No ____ Dates of service: _____
Type of service: _____

Are you currently in active duty or reserves: _____

Legal History: Do you have history of legal charges? Yes___ No___ Pending charges? Yes ___ No ___

Arrests? Yes ___ No___ Are you currently on probation or parole? Yes___ No___

Is treatment court ordered? Yes___ No___

If yes was checked for any of the above, explain: _____

_____

Family History:

Who raised you: _____

Who lives in your home with you: _____

Who are you closest to: _____

Parents: Please include names and ages of parents and step parents (if a deceased please include year and cause)

_____

Siblings: Please include names and ages of siblings and step siblings: _____

_____

Children: Please include names and ages of children and step children: _____

_____

Relationship Status: (check all that apply)

□ Married □ Separated □ Divorced □ Dating □ Widowed □ Living together

How long have you been in your current relationship? _____

*Married

What year did you get married: _____ Years Married: _____ How many times have you been married? ____

*Divorced

Have you been divorced: _____ Years Divorced: _____ How many times have you been divorced? _____

*Separated

How long have you been separated: _____ Where are you in the separation process_____

_____

*Widowed

How long have you been widowed: _____ How did you lose your spouse: _____

On a scale of 1-10 how would you rate your current relationship? _____

What are your relationship concerns? _____

_____

As you think about the primary reason that brings you here, how would you rate the frequency and your overall level of concern at this point in time?

*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 do you hope to accomplish through counseling? _____

_____

_____

What have you already done to deal with the difficulties? _____

_____

_____

What are your biggest strengths as a couple? _____

_____

Please rate your current level of relationship happiness about the relationship.

(very unhappy) 1 2 3 4 5 6 7 8 9 10 (very happy)

How enjoyable is your sexual relationship?

(extremely unpleasant) 1 2 3 4 5 6 7 8 9 10 (extremely pleasant)

How satisfied are you with the frequency of your sexual relations?

(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

What is your current level of stress (overall)?

(no stress) 1 2 3 4 5 6 7 8 9 10 (high stress)

What is your current level of stress (in the relationship)?

(no stress) 1 2 3 4 5 6 7 8 9 10 (high stress)

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 received prior couples counseling related to any of the above problems? □ Yes □ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? □ Yes □ No

If yes for either, who, how often and what drugs or alcohol?_____

_____

Have either you or your partner struck, physically restrained, used violence against/injured the other person? □ Yes □ No

If yes for either, who, how often and what happened. _____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? _____times

Rank order the top three concerns that you have in your relationship with your partner (1 being the most problematic):

1. _____

2. _____

3. _____

Is there anything else you feel we should know, or that you are concerned about? _____

_____

_____

Signature of person completing form: _____ Date: _____

Therapist Signature: _____ Date: _____

Couple Satisfaction Checklist

Place a check in the box to the right of each relationship category that best describes how satisfied you feel.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check 3 Areas You Want Most to Change
1. Degree of Closeness, Openness, Confiding, Sharing and Comforting							
2. Expression of Affection and Caring							
3. Satisfaction with Sexual Intimacy							
4. Handling Conflicts and Arguments							
5. Expression of Anger, Criticism or Blame							
6. Handling Family finances							
7. Handling of Parenting Issues							
8. Handling of Household Tasks							
9. Common Interests and Social Life							
10. Degree of Respect and Admiration for Your Partner							
11. Satisfaction with your Role in the Relationship							
12. Satisfaction with your Partner's Role in the Relationship							
13. Overall Satisfaction with Your Relationship							

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020