Couples Counseling Intake Form

ServingLeaders Ministries

A. CLIENT INFORMATION

First Name: Middle Initial: Last Name: Date of Birth:

_____ _____ _____ _____

Address: City: State: Zip:

_____ _____ ____ _____

Cell Phone: Home Phone: Email:

_____ _____ _____

Preferred method of contact:_____ Is it okay to leave a voicemail? ☐ yes ☐ no

Gender: ☐ Male ☐ Female Marital Status:_____ Ever Divorced: ☐ yes ☐ no

Occupation:_____ Employer: _____

Current Church Affiliation: Do you serve in a leadership role? (If so, what?)

_____ _____

B. SPOUSE INFORMATION

First Name: Middle Initial: Last Name: Date of Birth:

_____ _____ _____ _____

Address: City: State: Zip:

_____ _____ ____ _____

Cell Phone: Home Phone: Email:

_____ _____ _____

Preferred method of contact:_____ Is it okay to leave a voicemail? ☐ yes ☐ no

Gender: ☐ Male ☐ Female Marital Status:_____ Ever Divorced: ☐ yes ☐ no

Occupation:_____ Employer: _____

Current Church Affiliation: Do you serve in a leadership role? (If so, what?)

_____ _____

C. EMERGENCY CONTACT

Name: _____ Relationship to Client: _____

Phone: _____ Email:_____

D. INTAKE INFORMATION

Have you ever had counseling before? If yes, list the name of counselor and dates seen:

1) _____
2) _____
3) _____

How would you describe your experience with counseling in the past?

_____

_____

What has led you to seek counseling now?

_____

_____

_____

Referred by: _____

Where do your current difficulties affect you?

☐ Home ☐ Marriage ☐ Family ☐ Work ☐ Relationship with God ☐ Friends/Community ☐ Job

Have you ever or are you currently experiencing any of the following? (check all that apply)

- ❑ Alcohol abuse
- ❑ Drug use
- ❑ Impulsivity
- ❑ Concerns about finances
- ❑ Changes in sleeping habits
- ❑ Changes in appetite
- ❑ Feeling lonely
- ❑ Abuse (physical, verbal, emotional or sexual)
- ❑ Stress
- ❑ Feeling trapped in rooms/buildings/cars
- ❑ Hearing voices
- ❑ Overwhelming fear
- ❑ Panic attack(s)
- ❑ Chronic lying /stealing
- ❑ Increased anxiety/worry
- ❑ Unusual indecisiveness
- ❑ Inability to control thoughts
- ❑ Guilt
- ❑ Loss of concentration
- ❑ Feeling sexually attracted to members of your own gender
- ❑ Distrustful
- ❑ Hopelessness
- ❑ Hostile/angry/violent
- ❑ Feelings of being watched
- ❑ Loss of sexual desire
- ❑ Feeling distant from God
- ❑ Concerns about body image
- ❑ Frequent depressed mood
- ❑ Fatigue/low energy
- ❑ Hallucinations
- ❑ Obsessions/compulsions
- ❑ Apathy/Loss of interest

Have either of you ever or are you currently experiencing thoughts of suicide? ☐ yes ☐ no

In your own words, describe what you hope to accomplish/receive through this process:

_____

_____

_____

E. FAMILY INFORMATION

Number of years married: _____ Have you ever been married previously? ☐ yes ☐ no

List your children and their ages starting with the oldest:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

What is your parents' current marital status? If parent(s) are no longer living, please indicate their marital status before passing (mark for both sets of parents).

- ❑ Married
- ❑ Separated for ___ years
- ❑ Divorced for ___ years
- ❑ Mother remarried ____ times
- ❑ Father remarried ____ times
- ❑ Never married

Please describe your family experience growing up (mark for both of you):

- ❑ Optimal/Secure
- ❑ Adequate/Supportive
- ❑ Distant/Disconnected
- ❑ Controlling/Rule-bound
- ❑ Chaotic/Overwhelming
- ❑ Abusive/Unsafe

What support do you have in your life (Family, Friends, School, Work, Social/Community, Church)?

_____

_____

Is there a history of mental illness in your family (anxiety, depression, suicide, bipolar, schizophrenia, etc.)?

- ❑ Yes
- ❑ No
- ❑ Not Sure

If yes, please indicate which family members experienced mental illness (and explain):

- ❑ Father
- ❑ Mother
- ❑ Sibling(s)
- ❑ Grandparent(s)
- ❑ Spouse
- ❑ Child/children
- ❑ Step-parent/sibling (live-in)
- ❑ Other

_____

_____

_____

_____

Is there a history of alcohol/drug abuse in your family?

- ❑ Yes
- ❑ No
- ❑ Not Sure

If yes, please indicate with which family members (and explain):

- ❑ Father
- ❑ Mother
- ❑ Sibling(s)
- ❑ Grandparent(s)
- ❑ Spouse
- ❑ Child/children
- ❑ Step-parent/sibling (live-in)
- ❑ Other

_____

_____

_____

F. MEDICAL INFORMATION

Primary Care Physicians: Phone:

_____ _____

Address: City: State: Zip:

_____ _____ ____ _____

How would you describe your current physical health? ☐ Good ☐ Fair ☐ Poor

Please list any medications you are currently taking (include dosage):

1) _____
2) _____
3) _____

Have you had any serious conditions, illnesses, injuries and/or hospitalizations in the past?
(Please list with approximate dates.)

1) _____
2) _____
3) _____

Is there anything else that you would like your counselor to know?

_____

_____

_____

_____