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## Couples Counseling Intake Form

What brought you in for therapy? Please describe what your current issues are.

How long has the problem been present?

Any current stressors that I should be aware of?

Which of the following have you experienced?

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|---|---|
| <input type="checkbox"/> Suicidal Thoughts  | <input type="checkbox"/> Self Harm (Cutting)  |
| <input type="checkbox"/> Suicide Attempts or a Plan to harm yourself                          | <input type="checkbox"/> Thoughts or Plan to harm others                                  |
| <input type="checkbox"/> Substance Abuse/Dependence   | <input type="checkbox"/> Poor concentration/Difficulty focusing                           |
| <input type="checkbox"/> Addiction  | <input type="checkbox"/> Feelings of Hopelessness/Worthlessness                           |
| <input type="checkbox"/> Recovery Treatment for addiction such as alcohol, drugs, pornography | <input type="checkbox"/> Feelings of shame or guilt                                       |
| <input type="checkbox"/> Depression (sad, down, affecting biological functioning)             | <input type="checkbox"/> Racing Thoughts  |
| <input type="checkbox"/> High or low energy level   | <input type="checkbox"/> Flashbacks/ Nightmares   |
| <input type="checkbox"/> Angry/Irritable  | <input type="checkbox"/> Sexual Abuse   |
| <input type="checkbox"/> Loss of interest in activities                                       | <input type="checkbox"/> Anxious, Nervous or Tense  |
| <input type="checkbox"/> Difficulty enjoying things   | <input type="checkbox"/> Low Self Esteem  |
| <input type="checkbox"/> Crying spells  | <input type="checkbox"/> Hearing Voices   |
| <input type="checkbox"/> Decreased motivation   | <input type="checkbox"/> Paranoid Thoughts  |
| <input type="checkbox"/> Panic Attacks  | <input type="checkbox"/> Perfectionism  |
| <input type="checkbox"/> Shortness of Breath  | <input type="checkbox"/> Rituals of counting things, or needing things in a certain order |
| <input type="checkbox"/> Trouble sleeping   | <input type="checkbox"/> Issues with body image   |
| <input type="checkbox"/> Withdrawing from others  | <input type="checkbox"/> Eating disorder  |
| <input type="checkbox"/> Negative thinking  | <input type="checkbox"/> Binge eating/ purging  |
| <input type="checkbox"/> Change in weight or eating habits                                    | <input type="checkbox"/> Feeling a loss of control over eating                            |
| <input type="checkbox"/> Mood swings  | <input type="checkbox"/> Job problems   |
|   | <input type="checkbox"/> Adoption   |
|   | <input type="checkbox"/> Other  |

How long have you been in current relationship? \_\_\_\_\_

Describe the state of your relationship? \_\_\_\_\_

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What are the strengths in your relationship? \_\_\_\_\_

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What are some growth areas? \_\_\_\_\_

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What do you hope to accomplish through counseling? \_\_\_\_\_

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Have either you or your partner been in individual counseling before? Yes No

If so, give a brief summary of concerns that you addressed \_\_\_\_\_

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

If yes, how often and what drugs or alcohol? \_\_\_\_\_

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What types of arguments do you and your partner have? \_\_\_\_\_

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What is your current level of stress? (overall) 1 being no stress, 10 being high stress

1    2    3    4    5    6    7    8    9    10

What is your current level of stress in the relationship? 1 being no stress, 10 high

1    2    3    4    5    6    7    8    9    10

Please list the top three concerns that you have in your relationship with your partner

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Any history of neglect?      Physical Abuse?      Verbal, Emotional, Spiritual Abuse?  
Sexual Abuse?              Any family history of substance abuse?

Any family history of mental illness (including depression, anxiety)?

Any family history of suicide?

Any history of domestic violence?

Occupational History:

What is your current employment status?

- Employed Full Time       Employed Part Time
- Unemployed               Self Employed

{ } Student

If you are employed, Name: \_\_\_\_\_

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

Are you satisfied with your employment?

Any other information you feel is important for me to know at this time?

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Welcome to my practice. First of all, I want to commend you for taking the first steps toward hope and healing. The therapeutic process can provide such freedom. This document contains important legal and ethical information about my professional services and it is important that you take the time to read and understand it.

The therapeutic relationship is vital to the success of your therapy. Therapy works in part because of the clearly defined rights and responsibilities held by each person. As a client, you have certain rights. There are also legal limitations to those rights that you should be aware of.

### Goals of Counseling:

There can be many goals for the counseling relationship. And these goals can change or evolve as therapy moves forward. Some of these goals can be long term such as improving the quality of life, learning to live with mindfulness, recovery, or restored relationships. Others may be more immediate goals such as decreasing anxiety, symptom relief, changing a behavior, or increasing social support. Whatever the goals for therapy, they will be set by the client according to what they want to work on during their sessions. This is your journey and while I am there as a guide and support, it is imperative that you embrace the desire to change and do the work necessary to move towards your goals. I may make suggestions, but ultimately, the goals are yours and the time in therapy is yours.

### Risks/Benefits of Counseling:

Counseling is an intensely personal process. If you choose to enter into the journey, it can bring up painful memories, hurtful experiences or even reintroduce certain traumas into your thinking. There are no guarantees that therapy will work for you. Clients can make progress then return to old patterns of behaving. Progress may happen slowly. Counseling requires a very active effort on your part. In order to get the most out of therapy you will need to work on things, do the homework, engage in reflection outside of our sessions.

There are several benefits to therapy. Counseling can help you develop essential life skills, reduce symptoms of mental health issues, improve the quality of your life and relationships, develop healthy styles of relating, communicate more effectively, take better care of yourself, grow in knowledge, have more useful coping skills and develop confidence in who you were meant to be.

## Confidentiality:

Trust is at the heart of the therapeutic relationship. For this reason, every effort will be made to keep your personal information private. If you wish to have your information released we will discuss whether that is in your best interests, and you will be required to sign a consent form before such information is released to anyone. Safety is also at the heart of therapy. I have a legal and ethical responsibility to you and the community. Because of this, there are some limitations to confidentiality. I may consult with colleagues on your case to offer you the best possible help. In the even that I speak with another therapist, no identifying information such as your name will be released. Therapists are required by law to release information when the client poses a risk to themselves or others. As well I am a mandated reporter if there are any issues of child or elder abuse. If I am subpoenaed, I may be required by law to release information, but I would consult with other professionals and limit the release to only what is necessary by law. In keeping with the laws surrounding confidentiality, I also wanted to mention that if by chance, we should randomly see one another out in the community, I will not initiate a greeting. If you however were to recognize and greet me, I would respond appropriately, keeping in mind that anything you may want to share should be done in session.

## Appointments:

Appointments will be 50-60 minutes. We will decide together how often you would like to be seen. The time scheduled for you is designated for you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hours notice, you will be responsible to pay for your session. I understand that circumstances do arise that are out of your control. If this is the case, you will not be responsible for the fee. In addition, you are responsible for coming to your appointment on time. If you are late, your appointment will still need to end on time.

## Fee Schedule:

Appointment Fee	Income
\$200	\$90,000 plus
\$150	\$70,000-\$90,000
\$125	\$50,000-\$70,000
\$100	Less than \$50,000

You are responsible for paying at the time of your session unless prior arrangements have been made. Fees are not negotiable. To receive sliding scale fees, you must present proof of income through recent pay stubs or tax forms. Fees are subject to change at the therapist's discretion.

Confidentiality and Technology:

As your therapist I will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communication will not occur. If you prefer to communicate via email or telephone to arrange things like appointments or updates, please be advised of any friends, family or significant others who may have access to your phone or computer.

Contacting Me:

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. You may leave a message on my confidential voicemail and I will get back to you as soon as possible, but it may take a day or two for non-urgent matters. If you call on a Friday, I will return your call on Monday as I do not work on the weekends. If your call is urgent and you feel you cannot wait for a return call or it is an emergency, please go to your local hospital or call 911.

Clients

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Client Information:**

Patient Name:		Today's Date:			
Home Address:		Date of Birth:			
Home Phone:	Cell Phone:	Work Phone:			
May I leave a message?   Y   N					
Email:		Best way to reach you:			
Are you?	Married	Single	Separated	Divorced	Remarried
Do you have children?   Y   N					
If yes, names & ages:					

**Emergency Contact Information:**

In case of emergency, who should I contact?

Name:	Relationship:
Address:	Phone: