Couples Adult Intake Forms

IDENTIFYING INFORMATION

Name: ________________________________ Date: ____________________ Date of birth:____________________

Street Address: ____

City:______________________________ Province:__________________________ Postal Code:________________

Home phone: ____________________ Cell phone: ______________________ Work phone: ___________________

Best number to contact? _______________________________ Can we leave a voicemail? ____________________

Best email address to reach you: ____

Can we contact you by email to let you know about groups or other updates about the clinic? Yes No

Highest level of education: _________________________ Occupation: ____________________________________

Employer: ____ Hours worked per week: ____________________

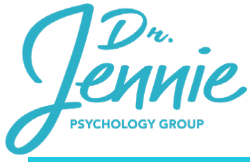
Race/Ethnicity: _______________________________ Religious Affiliation: ________________________________

How did you hear of Dr. Jennie Psychology Group? ____

Do you have extended Health Care Insurance? Yes No Insurance company name __________________________

Emergency contact name: ___________________________ Relationship __________________________________

City: _______________________________________ Phone number: _____________________________________



SPOUSE INFORMATION

Name of spouse/partner: ____

Occupation of spouse/partner: ____

Relationship Status: (Check all that apply)

□ Married □ Separated □ Divorced □ Dating

□ Cohabitating □ Living together □ Living apart

Length of time in current relationship: ____

Have you received prior couples counselling? Yes No

If yes, for what problems?

If yes, when: ____________________________________ Where:____

By whom: ______________________________________ Length of treatment:________________________________

Problems treated:

What was the outcome?

Very successful Somewhat successful No change Got worse

Have you had other previous therapy/counselling of any kind? Yes No

If yes, for how long?

What concerns were addressed in therapy?

____
____

Was this experience helpful (please explain)?

____
____

What are your expectations for counselling?

____
____
____
____

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

1. ____
2. ____
3. ____
4. ____

Whose idea was it to come to therapy? ____

What are your biggest strengths as a couple?

____
____
____
____

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

(Extremely Unhappy) 1 2 3 4 5 6 7 8 9 10 (Extremely Happy)

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems? Yes No

If yes, who? _________ Me __________ Partner __________ Both of us

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

Yes No

If yes, who? __________ Me _________ Partner __________ Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? Yes No

If yes, who? _______ Me _________ Partner __________ Both of us

How would you describe your relationship with your partner?

____
____
____
____

What does the ideal relationship look like to you?

____
____
____
____
____

What is required of you to bring about this ideal relationship?

____
____
____
____
____

How motivated are you to get to your ideal relationship? (On a scale from 1-10 where 10 is highly motivated)

(Unmotivated) 1 2 3 4 5 6 7 8 9 10 (Highly Motived)

Couples Satisfaction Checklist

Please place a check in the box that best describes how you feel.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check 3 areas you most want to change
Degree of closeness, openness, confiding, sharing and comforting							
Expression of affection and caring							
Satisfaction with sexual intimacy							
Handling of conflicts and arguments							
Expression of anger, criticism or blame							
Handling of family finances							
Handling of household tasks							
Common interests and social life							
Degree of respect and admiration for your partner							
Satisfaction with your role in the relationship							
Satisfaction with your partner's role in the relationship							

FAMILY INFORMATION

Did either of your parents have issues with drugs, alcohol, or other?

____
____
____
____

Describe your life as a teenager:

____
____
____
____

REASONS FOR SEEKING TREATMENT

Describe your life in the last 6 months:

____
____
____
____

Please briefly describe the problems you are currently experiencing:

____
____
____
____

What has happened to cause you to seek help NOW?

____
____
____
____

What do you consider to be other stresses in your life?

____
____
____
____

HISTORY OF PROBLEM

When did you first start experiencing the problem(s) that brought you to the office today?

____

____

How often does the problem occur? ____

How long does it last? ____

Do you have any thoughts of harming yourself? Yes No

Have you ever attempted to harm yourself? Yes No

If yes, please explain:

____

____

____

Do you have any thoughts of harming someone else? Yes No

Have you ever attempted to harm someone else? Yes No

If yes, please explain:

____

____

____

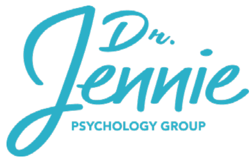
Have you experienced any trauma or abuse? Yes No

If yes, please explain:

____

____

____



Have you ever been hospitalized? Yes No

If yes, when/where was this, and for what reasons?

____

____

____

Do you currently do/take any of the follow?

Smoke? Yes No

If yes, how many packs per day/week? ____

Alcohol? Yes No

If yes, how much and how often? ____

Recreational drugs? Yes No

If yes, how much and how often? ____

Other? ____

FAMILY HEALTH

Have any family members been diagnosed with any of the following? (Please check if YES):

☐	Cancer	☐	Mental Retardation
☐	Tourette's Syndrome	☐	Anxiety
☐	Diabetes	☐	Seizures/Epilepsy
☐	Heart Disease	☐	Reading Problems
☐	High Blood Pressure	☐	Speech/Language Problems
☐	Behaviour Disorder (i.e., ODD)	☐	Attention Deficit/Hyperactivity Disorder
☐	Depression	☐	Sleeping Difficulties
☐	Autism Spectrum Disorder	☐	Alcohol/Drug Abuse
☐	Schizophrenia	☐	Kidney Disease
☐	Bipolar Disorder	☐	Migraine Headaches
☐	Multiple Sclerosis	☐	Physical Disability
☐	Alzheimer's Disease	☐	Stroke
☐	Other Learning Problems	☐	Tics
☐	Other significant health or emotional problem:		

Have you been diagnosed with any of the following?

☐	Cancer	☐	Mental Retardation
☐	Tourette's Syndrome	☐	Anxiety
☐	Diabetes	☐	Seizures/Epilepsy
☐	Heart Disease	☐	Reading Problems
☐	High Blood Pressure	☐	Speech/Language Problems
☐	Behaviour Disorder (i.e., ODD)	☐	Attention Deficit/Hyperactivity Disorder
☐	Depression	☐	Sleeping Difficulties
☐	Autism Spectrum Disorder	☐	Alcohol/Drug Abuse
☐	Schizophrenia	☐	Kidney Disease
☐	Bipolar Disorder	☐	Migraine Headaches
☐	Multiple Sclerosis	☐	Physical Disability
☐	Alzheimer's Disease	☐	Stroke
☐	Other Learning Problems	☐	Tics
☐	Other significant health or emotional problem:		

What kind of stressful events have family members experienced recently?

____
____
____

What kinds of stressful events have you experienced recently?

____
____
____

MEDICAL CARE AND HISTORY

Family Physician: __________________________________ Clinic Name: _________________________

Clinic phone number: ____________________ How often do you see a doctor? _____________________

Date of last visit: ____

Naturopathic Doctor: ____

Have you been prescribed medications? Yes No

Please list all current medications/supplements you are currently taking:

____
____
____

Do you have any history of the following?

Condition	Age	Treated by Whom?	Outcome of treatment
Serious Accidents			
Head injury			
Serious illness			
Eye, ear, nose, or throat problems			
Seizures			
Allergies			
Loss of consciousness			
Hospitalizations			
Other:			

EDUCATION

What is the highest level of education you have achieved so far? ______________________________________

What are your educational/career goals? ____

Describe any difficulties you are having achieving your goals:

____
____
____

WORK

Are you currently working? Yes No

If yes, how often?

____

Are you satisfied with your current employment situation?

____

PARENTING

Children? ____________________________ Number of Children: ____

Name: ________________________ Gender: __________________ Age: _______ Living with you? _______________

Name: ________________________ Gender: __________________ Age: _______ Living with you? _______________

Name: ________________________ Gender: __________________ Age: _______ Living with you? _______________

Name: ________________________ Gender: __________________ Age: _______ Living with you? _______________

Describe your approach to parenting:

____

____

____

What challenges do you experience parenting your child/children?

____

____

____

What areas of your parenting do you want support with?

____

____

____

Describe your relationship with your child/children:

____

____

____

FRIENDSHIPS

Do you have close friends to talk to? Are you happy with the friendships you have?

____

____

____

INTERESTS AND ACTIVITIES

Please describe your strengths and positive characteristics:

____
____
____

What extracurricular activities (i.e., sports, music, clubs, religious organizations) do you participate in?

____
____
____

What hobbies or interests do you have?

____
____
____

Any other information you feel is important and was not asked about?

____
____
____