Positive Changes Counseling Center, Debbie Disney, LCSW-C, LLC

New Client Intake Form: Couples

Please complete separate forms for each person and bring to your first session.
Please note: the information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Insurance type (Aetna, BCBS, Cigna, etc.): _____

Name of Primary Insurance Policy Holder: _____

Birth Date of Insurance Policy Holder: _____/_____/_____

Address: _____
(Street and Number)
_____
(City) (State) (Zip Code)

Cell Phone: ( ) May we leave a message? ____Yes ____ No

May we leave a text message on your cell phone? ____Yes ____ No

Email: _____

May we email you? ____Yes ____ No

***Please note: Email correspondence and text messaging are not considered to be confidential mediums of communication.**

How did you find us? _____

Please list any children and their age(s):

Name	Age	Gender	Lives
_____	____	____F ____M	__Home __Away
_____	____	____F ____M	__Home __Away

_____ ____ ____F ____M __Home __Away

_____ ____ ____F ____M __Home __Away

Marital Status:

____ Domestic Partnership ____ Married ____ Separated ____ Divorced

How long have you been in a relationship? _____

On a scale of 1-10 (1 being extremely dissatisfied and 10 being very satisfied), how would you rate your relationship? _____

On a scale of 1-10 (1 being extremely dissatisfied and 10 being very satisfied), how would you rate your ability to handle conflicts and arguments? _____

On a scale of 1-10 (1 being extremely dissatisfied and 10 being very satisfied), how would you rate your partner's role in the relationship? _____

On a scale of 1-10 (1 being extremely dissatisfied and 10 being very satisfied), how would you rate your role in the relationship? _____

On a scale of 1-10 (1 being extremely dissatisfied and 10 being very satisfied), how would you rate your intimacy in the relationship? _____

Have there been concerns about unfaithfulness in the relationship? ____Yes ____ No

Are there current or upcoming legal proceedings? (ex. divorce, mediation, custody, etc.)
____Yes ____ No

Work/School:

Are you currently employed? ____ Yes ____ No
If yes, what is your current employment situation? _____
_____

Are you currently a student? ____ Yes ____ No
If yes, please provide the name of your school and grade: _____
_____

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

Family Mental Health History:

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex. Maternal grandmother, father, paternal grandfather, etc.)

	Please Circle:	Family Member(s):
ADHD/ADD	Yes / No	_____
Alcohol/Substance Abuse	Yes / No	_____
Anxiety	Yes / No	_____
Depression	Yes / No	_____
Domestic Violence	Yes / No	_____
Eating Disorders	Yes / No	_____
Disordered Eating	Yes / No	_____
Obsessive Compulsive Behavior	Yes / No	_____
Mental Illness	Yes / No	_____
Suicide	Yes / No	_____
Other: _____	Yes / No	_____

General Health and Mental Health Information:

Name of Primary Care Provider: _____

Have you previously received any type of mental health services (psychotherapy, psychiatrist services, etc.)? ____ Yes ____ No

If yes, please list previous therapist: _____

Are you currently receiving therapy for individual services? ____ Yes ____ No

If yes, please list current therapist: _____

Have you ever been prescribed psychiatric medication? ____ Yes ____ No

If yes, please list and provide dates you were first prescribed: _____
_____

Are you currently taking any prescription medication? ____ Yes ____ No

If yes, please list: _____

Name of Psychiatrist or Medical Practitioner: _____

Are you experiencing sadness, grief, or depression? ____ Yes ____ No

If yes, for approximately how long? _____

Please explain: _____

Are you experiencing anxiety, anxiety attacks, or panic attacks? ____ Yes ____ No

If yes, for approximately how long have you been experiencing this? _____
_____

Please explain: _____

Do you have any phobias? ____ Yes ____ No

Please explain: _____

Are you experiencing chronic pain? ____ Yes ____ No

If yes, please explain: _____

_____

Is there a history of self harm, suicidal thoughts, etc.? ____ Yes ____ No

Do you drink alcohol? ____ Yes ____ No

If yes, how often? _____

Do you engage in recreational drug use? ____ Yes ____ No

If yes, how often? _____

Do you use a medical marijuana card? ____ Yes ____ No

Have you experienced any significant life changes or stressful events?
_____
_____
_____
_____

What self care activity do you enjoy? _____
_____

What do you consider to be your strengths within the relationship?

_____
_____

What do you consider to be your weaknesses within the relationship?

_____
_____

Please describe the main difficulties or concerns that have brought you to therapy.

_____
_____
_____
_____
_____
_____

What are your goals for therapy?

_____
_____
_____

Is there anything else you would like me to know about you that is not on this form?

_____
_____
_____
_____
_____