RiverLife Wellness Center
Couples Therapy Intake Form

Confidential. Please print clearly

Date: _____

Name and Date of Birth: (Him)_____DOB: _____

Name and Date of Birth (Her)_____DOB: _____

Address:_____

City: _____ State:_____ Zip Code: _____

Home Phone:_____

His cell:_____ Her Cell: _____

Which of these is the best way to reach you? _____

Email Address: Him:_____ Her:_____

Emergency Contact: _____ Relationship:_____

Telephone:_____ Email:_____

Do you have any sibling? Him_____ How many?_____ Her_____How many? _____

Previous Marriages? Him_____ How many? _____ Her_____ How many? _____

Are your parents divorced? Him_____How old were you? _____ Her_____ How old were you?_____

Please give the following information for each person that currently lives in your home, **including yourself**:

Name	Age	Relationship to Self

Personal & Medical Information (please indicate whom)

Are you currently taking any prescription medication? _____

Medication	Prescribed For?	Frequency	Dosage

Who is your Primary Care doctor? Him_____ Her_____

List any past or present medical issues: Him_____

Her:_____

Date of last physicals: (Him)_____ (Her)_____

Have either of you had thoughts of harming yourself or ending your life?

Him: _____ Her: _____

Family History (please **include yourself** in this and specify whom it is in your family)

Alcoholism/Drug Abuse: _____

Depression, Mani/Depression, Schizophrenia:_____

Other Mental Illness:_____

Emotional, Physical, Verbal, Sexual Abuse:_____

Other Significant Childhood Trauma:_____

Other Background Information

Have you seen a therapist before? Yes No If so how long ago? _____

Was it helpful? Yes No How or how not?_____

_____

PRESENT CONCERNS

Please circle each concern or symptom experienced recently and indicate if husband/wife.

Abuse (sexual, emotional, physical)

Addiction

- Alcohol
- Gambling
- Tobacco
- Prescription Medication
- Other _____

Aggression, violence

Anger, hostility, arguing, irritability

Anxiety, nervousness

Attention, concentration, distractibility

Career concerns, goals, and choices

Children, childcare, parenting

Codependence-unhealthy attachments

Confusion

Decision making, indecision

Delusions

Depression, low mood, sadness, crying

Divorce, separation

Eating problems-overeating, under eating, vomiting

Fatigue, tiredness, low energy

Fears, phobias

Financial or money troubles

Frequent pain

Friendships

Grieving, mourning, deaths, losses, divorce

Guilt

Health, illness, medical concerns, physical problems

Hopelessness

Inferiority feelings

Impulsiveness

Legal matters

Loneliness

Marital conflict, distance, infidelity, remarriage

Memory problems

Mood swings

Motivation, laziness

Nervousness, tension

Obsessions, compulsions (thoughts or actions repeat themselves)

Panic or anxiety attacks

Perfectionism

Pessimism

Pornography use

Procrastination

Relationship problems

School problems

Self-esteem

Self –neglect, poor self care

Sexual issues, dysfunctions, conflicts, desire differences

Sleep problems- too much, too little, insomnia, nightmares

Smoking and tobacco use

Stress, relaxation, stress management

Work problems

Any other issues not listed above?

What do you hope to accomplish through counseling?

What have you already done to deal with these difficulties?

What are your biggest strengths as a couple?

Client Signature:_____ Date:_____

Client Signature:_____ Date:_____