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Couples Intake Questionnaire

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

Preferred Name (if different):_____

Partner's Name: _____

Your Birth Date:_____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Ethnicity/Race: _____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐Married ☐ Separated

☐ Divorced ☐Widowed ☐ Common-law married

How how long have you been in your current relationship? _____

Please list any children/age/gender/biological or other:

_____

_____

Home Phone: _____ May we leave a message? ☐Yes ☐No

Cell/Other Phone: _____ May we leave a message? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐No

Which of the above communication forms do you prefer to receive updates and appointment reminders?
□ Email □ Cell Phone □ Home Phone □ Any of these

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes, Previous therapist/practitioner: _____

How long ago were you seen? _____

How long did you see them? _____

What did you see them for and what was helpful or not helpful?

_____

_____

If you've seen multiple providers for mental health please continue to list them here:

_____

_____

_____

_____

You may continue to list them on the back of this sheet if necessary.

Have you ever been prescribed psychiatric medication?

☐ Yes

☐ No

If yes, please list what medications, who prescribed them and if you are currently taking them:

_____

_____

_____

Are you currently taking any other prescription medication?

☐ Yes

☐ No

If yes please list the medications and conditions it is treating:

_____

_____

_____

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

2. Please list any specific health problems you are currently experiencing:

   _____

   _____

3. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

4. Please list any specific sleep problems you are currently experiencing:

   _____

   _____

5. Do you engage in exercise on a regular basis? ☐ Yes ☐ No

   If yes, how often do you exercise on a weekly basis? _____

   What types of exercise to you participate in: _____

   _____

6. Please list any difficulties you experience with your appetite or eating patterns.

   _____

   _____

7. Are you currently experiencing any chronic pain? ☐ Yes ☐ No

   If yes, please describe? _____

8. Do you drink alcohol more than once a week? ☐ Yes ☐ No

   If yes, how often do you drink alcohol each week? _____

9. Do you currently engage in recreational drug use? ☐ Yes ☐ No

   If yes, how often do you use recreational drugs? ☐ Daily ☐ Weekly ☐ Monthly ☐Infrequently
   What substances do you use? _____
   When was the last time you used recreational drugs? _____

10. Do you have any history of substance use or abuse? ☐ Yes ☐ No
    If yes, please describe: _____

Personal History

1. Where were you born and where were you raised?

2. Who were your primary caregivers growing up? (both biological parents, adopted, mother and stepfather, single mother, etc.)

3. Were you an only child or did you have siblings? Please describe: _____

4. Describe your home life growing up (chaotic, normal, moved around a lot, etc):

5. Describe any major life events growing up (deaths, trauma, medical issues, abuse):

6. What is the highest level of education you completed? _____

7. Describe your relationship history including history of divorce, long-term relationships, death or loss, how many times you've been married, how long you were together, and any abuse issues that may have occurred.

Family History

1. Is there any family history of mental illness that you are aware of? ☐ Yes ☐ No
   If yes, please describe the family member's relationship to you and their mental health issues:

2. Has anyone in your family ever been hospitalized for psychiatric-related issues? ☐ Yes ☐ No
   If yes, which family members, how long were the hospitalized, and for what reasons?

   _____

   _____

3. Is there any other important family history medical or not that you would like me to know?

   _____

Current Information about Your Life

1. How would you describe your social life and friendships? ☐ Good support system ☐ Few friends

   ☐ Other: _____

2. Do you have any military background? ☐No ☐ Yes

   If Yes, Please describe status (retired, honorable discharge, etc) as well as branch of the military and other history:_____

   _____

3. Are you currently employed? ☐ Yes ☐ No
   If yes, what is your current occupation? _____
   Do you enjoy your work? Is there anything stressful about your current work?

   _____

4. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No
   If yes, describe your faith or belief:

   _____

   _____

5. What do you like about your relationship and want to keep the same?

   _____

   _____

6. What do you NOT like about your relationship and want to change?

   _____

   _____

   _____

7. What would you like to accomplish out of your time in therapy?

   _____

   _____

   _____

   _____

Please complete this form before your initial session and you can scan to email or bring it in with you. We will review the answers together and it is extremely helpful in streamlining the initial intake process.

Thank you and I look forward to meeting with you!

Amy Urbanek, LPC, NCC

amyurbaneklpc.com