Name_____

Date_____

Couples Intake Evaluation

FAMILY AND MARITAL HISTORY

Father _____ Age _____ Yr. Deceased _____
Mother _____ Age _____ Yr. Deceased _____

Siblings Name Age Where living
_____-_____-_____
_____-_____-_____
_____-_____-_____
_____-_____-_____

Children _____-_____-_____
_____-_____-_____
_____-_____-_____
_____-_____-_____

Marriage Spouse/Partner Name _____
Current status: Married _____ Divorced _____ Single _____ Widowed _____
Year(s) married _____ # of previous marriages _____
Dates of previous marriages _____

PRESENTING PROBLEMS

Describe the problem(s) that brought you here today:

Have you ever been in counseling before? _____Yes _____ No
If yes, describe experience/results: _____
_____
_____

History of legal problems _____Yes ____ No

History of financial problems _____ Yes ____ No

Name_____

Date_____

MEDICAL

Significant medical history _____

_____

Current medications _____

Allergies _____

Current medical problems _____

Primary Care Physician _____

SUBSTANCE USE HISTORY

Do you use/have used tobacco? _____currently _____ past _____ no

Do you use/have used alcohol _____ currently _____ past _____ no

Do you use/have used drugs _____ currently _____ past _____ no

Do you consider your use of any substances to be problematic? _____ yes _____ no

Are there any other addictive/compulsive problems? _____ yes _____no

If yes, explain _____

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY HAVING:

Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	
Feelings of extreme happiness		Change in sexual interest	
Trouble performing your job		Problems with family/friends	
Lack of enjoyment of usual activities		Feeling stressed	
Self esteem problem		Easily irritated	
Perfectionism		Feeling guilty	
Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts about hurting yourself/others		Thoughts about killing yourself/others	

Please look over the list and identify the symptoms that are causing you the most concern now:

_____

_____

_____

Is there anything that should be discussed that has not been identified that might have an impact in counseling _____

_____

_____

_____

_____