

Charlotte Hilber, MA LMFT

Confidential Intake Form – Couple

**Each person is to complete their own separate form*

Name: _____ Date: _____

Address: _____
Street City State Zip

Preferred phone number to contact me: _____ (cell home work) -OK to leave msg? Yes No

Another number to contact me: _____ (cell home work) -OK to leave msg? Yes No

Occupation: _____ Employer: _____

Okay to contact you by mail? Yes No Age: _____ Date of Birth: _____ Gender: F M

Relationship Status: NOT IN A RELATIONSHIP MARRIED _____ YEARS COHABITING-LENGTH OF TIME _____
ENGAGED-LENGTH OF TIME _____ SEPARATED-LENGTH OF TIME _____ DIVORCED-_____ YEARS WIDOWED _____ YEARS

FAMILY & RELATIONSHIPS

Please list other people living in the home with you:

FULL NAME	AGE	GENDER	RELATIONSHIP TO YOU

Please list any of your children living outside your home:

FULL NAME	WHO THEY ARE WITH	AGE	GENDER

HEALTH & STRESS

My overall general health is: Excellent Good Fair Poor **Date of last physical exam:** _____

List any past & current physical conditions, serious illness, allergy, surgery, injury, hospitalization, & number of pregnancies: None

List medications presently used & what they are for: None

Are you currently receiving care from a *counselor/therapist*? No Yes

Have you received care from a *counselor/therapist* in the past? No Yes (please give brief summary)

Are you currently receiving care from a *psychiatrist*? No Yes, from (name) _____

Have you received care from a *psychiatrist* in the past? No Yes

Have you ever been hospitalized for psychological problems? No Yes: month & year _____

What medications have you taken in the past for emotional or mental problems? None

Is there any history of mental illness in your family? No Yes

Have you experienced any of the following at any point in your life?

emotional/psychological abuse physical abuse sexual abuse none

Please check/circle all the substances you have used, past & present:

	NOW	PAST		NOW	PAST
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Other Opiates (Vicodin, Darvocet, Percodan, Oxycontin)	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	Depressants (Valium, Xanax, Rohypnol, Ativan, Klonopin, GHB, Quaaludes)	<input type="checkbox"/>	<input type="checkbox"/>
Crack/Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	Nicotine	<input type="checkbox"/>	<input type="checkbox"/>
Heroin, Chiva	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine	<input type="checkbox"/>	<input type="checkbox"/>
LSD, PCP, Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>			
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>			

When did you first use these? _____

How often do you use these? _____

How much do you currently use? _____

When did you last use? _____

Have you ever been involved with the legal system? (criminal, divorce, custody, civil, etc) No Yes: If yes, in what way?

Do you have a religious or spiritual belief system that influences your life? No Yes: _____

From your point of view, what are the major issues in the relationship bringing you to therapy?

Of those issues, which do you consider to be the most serious?

Have you ever been to counseling as a result of a problem in this relationship prior to today? No Yes:

What are you hoping will be different as a result of **this** therapy?

Do you perceive that either you or your partner has withdrawn from the relationship? No Yes: If yes, which of you has withdrawn? _____

Have either of you threatened to leave the other/separate or divorce as a result of the current relationship problems? No Yes: If yes, which of you? _____

Have either you or your partner struck, physically restrained or used violence against, or injured the other person within the last three years? No Yes: If yes, --who, how often, & what happened?

How satisfied are you with your sexual relationship this past month? (Circle one) Very Satisfied Satisfied Not Satisfied

To what degree do you have family or friends that support you as a couple? Very high High Moderate Low Very low

To what degree do the two of you share a similar basic world-view? Very high High Moderate Low Very low

Is there anything about your relationship that you do **not** want to change, that you want to keep the same?

Your Signature: _____ Date: _____