

Couple Intake Form

Date: _____ Referral Source: _____

CURRENT COUPLES COUNSELING NEEDS

(use additional paper as necessary)

Define Current Problem Areas: _____

Describe Most Important Outcomes Desired: _____



PARTNER ONE:

Name: _____ Age: _____

Birthdate: _____

Phone cell: _____ OK to leave message? Y_____ N_____

Phone other: _____ OK to leave message? Y_____ N_____

Email: _____ OK to leave message? Y_____ N_____

Street Address: _____
street

city, state, zipcode

Emergency Contact: _____

(use additional paper as necessary)

THERAPY/COUNSELING HISTORY

Describe Prior Therapy/Counseling: _____



Problems Addressed: _____

How helpful was therapy? _____

Current Prescribed Medication(s): _____

Current Alcohol Use: _____



Most Recent Hospitalization & Medical Condition: _____

LEGAL HISTORY, do not include divorce

Past Month: _____

Past 6 Months: _____

Past Year: _____

More than 1 Year ago: _____

Current Therapy/Counseling: _____

How is therapy going? _____



8383 NE Sandy Blvd, Suite 440, Portland, OR 97220

503-220-1332

crossenj@easystreet.net

www.CouplesDoingBetter.com

MEDICAL HISTORY

Current Primary Care Provider

Name: _____

Phone: _____

Address: _____
street

city, state, zipcode

Current Significant Medical Problems: _____

SIGN BELOW to affirm the truth of the information provided in these forms.

Signature _____ Date: _____



PARTNER TWO:

Name: _____ Age: _____

Birthdate: _____

Phone cell: _____ OK to leave message? Y_____ N_____

Phone other: _____ OK to leave message? Y_____ N_____

Email: _____ OK to leave message? Y_____ N_____

Street Address: _____
street

city, state, zipcode

Emergency Contact: _____

(use additional paper as necessary)

THERAPY/COUNSELING HISTORY

Describe Prior Therapy/Counseling: _____



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Signature _____ Date: _____

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