DR. JOHN "JACK" CROSSEN
COUPLES DOING BETTER

8383 NE Sandy Blvd, Suite 320A, Portland, OR 97220
503-220-1332
crossenj@easystreet.net
www.CouplesDoingBetter.com

Couple Intake Form

Date: ______________________ Referral Source: ____________________________________

CURRENT COUPLES COUNSELING NEEDS

(use additional paper as necessary)

Define Current Problem Areas: ____

____

____

____

Describe Most Important Outcomes Desired: ____

____

____

____

____

____

____

____

____

8383 NE Sandy Blvd, Suite 320A, Portland, OR 97220
503-220-1332
crossenj@easystreet.net
www.CouplesDoingBetter.com

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: ____

____

____

____

____

8383 NE Sandy Blvd, Suite 320A, Portland, OR 97220
503-220-1332
crossenj@easystreet.net
www.CouplesDoingBetter.com

Problems Addressed: ___

___

___

___

___

How helpful was therapy? ___

___

___

___

___

Current Prescribed Medication(s): ___

___

___

___

___

Current Alcohol Use: ___

___

___

8383 NE Sandy Blvd, Suite 320A, Portland, OR 97220
503-220-1332
crossenj@easystreet.net
www.CouplesDoingBetter.com

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 320A, 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: ______________________

8383 NE Sandy Blvd, Suite 320A, Portland, OR 97220
503-220-1332
crossenj@easystreet.net
www.CouplesDoingBetter.com

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: ____

____

____

____

____

8383 NE Sandy Blvd, Suite 320A, Portland, OR 97220
503-220-1332
crossenj@easystreet.net
www.CouplesDoingBetter.com

Problems Addressed: ____

____

____

____

____

How helpful was therapy? ____

____

____

____

____

Current Prescribed Medication(s): ____

____

____

____

____

Current Alcohol Use: ____

____

____

8383 NE Sandy Blvd, Suite 320A, Portland, OR 97220
503-220-1332
crossenj@easystreet.net
www.CouplesDoingBetter.com

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 320A, 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: ____________________

COPYRIGHT 2017 | JOHN "JACK" CROSSEN
ALL RIGHTS RESERVED