COLLABORATIVE INSIGHTS, LLC
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Client Intake Form - Couples

Personal information - Primary Client (financially responsible):

Name (First, MI, Last) ▼		Birth date (month/day/year) ▼ / /	Age ▼
Home address (number and street) ▼	Apt. no. ▼	City/town ▼	State ▼	Zip ▼
Phone number where you may be reached and messages left ▼ ◯Cell ◯Home ◯Work		Email address ▼	
In emergency, contact: ▼	Phone: ▼	Relationship: ▼	

Spouse/Partner:

Name (First, MI, Last) ▼		Birth date (month/day/year) ▼ / /	Age ▼
Home address (number and street) ▼	Apt. no. ▼	City/town ▼	State ▼	Zip ▼
Phone number where you may be reached and messages left ▼ ◯Cell ◯Home ◯Work		Email address ▼	
In emergency, contact: ▼	Phone: ▼	Relationship: ▼	

Social/Family Information

Which best describes you? Choose all that apply: ▼

◯ Never married ◯ Domestic partnership ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Engaged ◯ Living together

If you are currently in a romantic relationship, how long have you been in this relationship? (years, months)

On a scale of 1 to 10, (with 10 being best) how would you rate your satisfaction with your current relationship?

Do you have children? If so, please provide their names and ages, and indicate with who they live:

Name: _____ Age: _____ Live with: _____
Name: _____ Age: _____ Live with: _____
Name: _____ Age: _____ Live with: _____

Name: _____ Age: _____ Live with: _____
Name: _____ Age: _____ Live with: _____
Name: _____ Age: _____ Live with: _____

List any other individuals living in your home (other than you and any children listed above):

Medical/Mental Health History and Information

Primary Client

Are you currently taking medication?

◯ No ◯ Yes - please list medications and doses:

Spouse/Partner

Are you currently taking medication?

◯ No ◯ Yes - please list medications and doses:

Medical/Mental Health History and Information (continued)

Primary Client

Have you ever seen a psychiatrist or any other mental health provider?

○ No ○ Yes - please complete the following:

Focus of treatment: _____

_____

_____

_____

Is/was the treatment helpful? ○ Yes ○ No

If current, please list the name of your mental health provider:

_____

Secondary Client

Have you ever seen a psychiatrist or any other mental health provider?

○ No ○ Yes - please complete the following:

Focus of treatment: _____

_____

_____

_____

Is/was the treatment helpful? ○ Yes ○ No

If current, please list the name of your mental health provider:

_____

Counseling Concerns

Please list the issues for which you are seeking counseling. Be as specific as possible. (These could be collective concerns as a couple, or separate concerns.)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

What have you previously tried to address/resolve these issues? Has anything been helpful? (Collective and/or separate)

_____

_____

_____

_____

What are some of you coping strategies (collective and/or separate)?

_____

_____

_____

_____

What do you consider to be your strengths as a couple?

_____

_____

_____

_____

Counseling Goal(s)

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you and your partner hope to address and achieve in counseling. Please be as specific as possible. Your goals can be collective or separate.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____