2209 E Market St
York, PA 17402
Phone: (717)759-1024

Intake Form- Couples

Please complete this form to the best of your knowledge. Please know that all content shared on this intake form will be held confidential and not shared without your consent. If there is anything that you wish to not share, leave those questions blank. If there are any questions that do not pertain to you, please mark that as N/A and move to the next. Please place initials of which client the answers are pertaining to.

Name (1) _____ Date_____

Date of Birth _____ Phone number_____

Can a message be left on the voicemail? ( ) yes ( ) no

Address_____

Preferred Pronouns_____ Gender_____

Name (2) _____ Date_____

Date of Birth_____ Phone number_____

Can a message be left on the voicemail? ( ) yes ( ) no

Address_____

Preferred Pronouns_____ Gender_____

Are there any special needs that should be noted? Hearing aid devices, interpreter, mobility assistance, ect.?

_____

Is there a religion consideration that you would like the therapist to know yes ( ) no ( )

If yes, please explain _____

Emergency Contact (name & number) _____

How did you find Therapeutic Family Connections? _____

Presenting Difficulty

THERAPEUTIC FAMILY Connections

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When did you first start facing difficulties within your relationship? If there was a triggering event, what was it?

Have you been to therapy before and what was your experience like? (With whom, when and outcome)

What are the areas of concern? Why are you seeking therapy?

What are your individual goals of couples counseling? What would you hope to accomplish? In what areas would you like to improve, learn, and develop?

If therapy was successful, how would you know?

What have you already tried to resolve your challenges?

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How do each of you handle conflict with each other?

Do arguments ever escalate to the point where either of you feel unsafe? If so, please explain.

How would you describe physical intimacy in your relationship?

Please circle the number that indicates how motivated you are for change.

1 2 3 4 5 6 7 8 9 10

Minimally Motivated Moderately Motivated Highly Motivated

What are your individual strengths and strengths as a couple?

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What was the beginning of your relationship like?

Please list all prescribed, over the counter, and homeopathic medications that you are currently taking.

Medication name	Dose	Dosage Instructions	Prescribed By	What is the medication prescribed for?

Please check any past psychiatric medications that have been taken, date they were taken, and how helpful they were. Please list what you remember.

Please indicate any current or past treatment that you have been involved in.

Yes	No	Treatment	When	Were	Outcome
		Drug/Alcohol Treatment			
		Outpatient Therapy			
		Partial Hospitalization			
		Psychiatric Hospitalization			

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		Support Groups			

Additional space for other treatments that are not listed

Any **past** or **current** thoughts/plans/acts/ideation or intention of suicide? Please explain or write N/A if it does not apply.

Any **past** or **current** thoughts/plans/acts/ideation or intention of homicide? Please explain or write N/A if it does not apply.

Any **past** or **current** thoughts/plans/acts/ideation or intention of self-harm? Please explain or write N/A if it does not apply.

Has anyone in your social circle or family ever died by suicide? If yes, please explain.

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_____

_____

Family History

Has anyone in your family ever been diagnosed and treated for. If so, who?

Alcohol abuse_____

Anxiety _____

Bipolar disorder _____

Depression _____

Intellectual disabilities _____

Eating Disorders _____

Panic Attacks _____

Personality Disorder _____

Post-Traumatic Stress Disorder _____

Substance abuse _____

Have you or your partner ever taken psychiatric medications. If yes, who took what medications and how effective treatment was?

_____

_____

_____

_____

Who are your individual supports and who supports you as a couple?

_____

_____

_____

Relationship History

Are you currently Married ( ) Divorced ( ) Single ( ) Widowed ( ) In a relationship ( )

How long have you been together? _____

Are you at risk of splitting up? Yes ( ) No ( ) Unsure ( )

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Please explain _____

Have you been married before? _____

Are you sexually active? _____

Do you have any children yes ( ) no ( )

If yes, list name, ages, and gender

_____

_____

_____

_____

Describe your relationship with your children.

_____

_____

_____

_____

Who do you live with (names, gender, and ages)?

_____

_____

_____

_____

Substance Use

Please check all that applies to current and past substance use. If non-applicable, move to the next section.

Substance Type	Yes	No	Current Use (Within 6 months)	Amount / Frequency	Yes	No	Past Use	Amount/ Frequency
Alcohol								
Caffeine								
Crack/ Cocaine								
Ecstasy								
Heroin								
Inhalants								

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Marijuana								
Methamphetamines								
Nicotine Vape								
Painkillers- Not prescribed								
PCP/LSD								
Prescription Pills								
Sleeping Pills								
Stimulants								
Steroids								
Tobacco								

Are you currently in need of treatment for your substance use? ( ) yes ( ) no

When was the last time there was substance use and what substance was it? _____

Has your use of substances interfered with your daily life? _____

Has your substance use ever interfered with any relationships? _____

Has your substance use caused any legal problems? _____

Have you found yourself using more substances over time? _____

Is there any history of gambling? If yes, please explain _____

Is there any history of sexual acting out, pornography, sex crimes, legal charges, harmful behaviors, etc.?

_____

Is there any history of overeating, bingeing, restricting, and / or purging food?

_____

Medical History

Please check all medical history that applies to you or anyone in your family. Please mark you, or which family member the condition applies to.

Allergies_____ Asthma_____ Cancer (type)_____

Chronic Fatigue_____ Chronic Pain_____ Diabetes_____

Epilepsy / Seizures_____ Fibromyalgia_____ Head trauma_____

Heart Disease_____ High Blood Pressure_____ High Cholesterol _____

Infectious Disease_____ Stomach / GI Problems_____ Thyroid Disease_____

Other_____

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Past medical difficulties, including surgeries and hospitalizations? Please explain or write N/A

_____

_____

_____

_____

Any allergies or special precautions that should be known about?

_____

_____

_____

_____

For Women Only

Date of your last menstrual cycle? _____

Are your menstrual cycles consistent each month? _____

Are you currently pregnant, or do you think you may be pregnant? _____

Are you planning to get pregnant in the near future? _____

Birth control method? _____

Do you have any concerns about your physical or reproductive health that you would like to discuss in therapy?

_____

Were there any complications when your mother was pregnant with you or during birth?

_____

Trauma History

Have you ever experienced any of the following? Check all that apply

( ) Emotional Abuse ( ) Sexual Abuse ( ) Domestic Violence

( ) Physical Abuse ( ) Neglect ( ) Caregiver Abuse

( ) Verbal Abuse ( ) Witnessed Abuse

Additional space for any other experiences

_____

_____

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Have you ever received treatment for any of the experienced trauma? If so, where, from whom, and when?

_____

_____

_____

What was the outcome of the treatment?

_____

_____

_____

Are you currently safe? ( ) yes ( ) no

Educational / Occupation History

Highest grade completed? _____

Where did you complete your highest grade level? _____

Are there any academic difficulties? _____

Is there a history of developmental delays? ( ) yes ( ) no

If yes, please explain _____

What are your strengths in your academics? _____

What is your learning style? (Auditory- by hearing information, Kinesthetic- by doing, Read / Write, or Visual)

_____

Did you attend College? _____

If yes, where? _____

What was your major? _____

Are you currently ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

If you are working, what is your occupation? _____

How long have you been at your current employer? _____

What is your work schedule? _____

Have you ever been in the military? _____

If yes, which branch and when? _____

Are you still active duty? _____

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Were you discharged honorably? Yes ( )_ no ( )

If not honorably discharge, please explain _____

Legal History

Have you ever been arrested? If yes, please explain (when and for what) _____

Have you ever been to jail / prison? When and for what _____

Do you have any pending legal problems? If yes, please explain. _____

Have you ever been on parole or probation? If yes, please explain. _____

Any additional information that would be helpful for your therapist to know?

_____

_____

_____

_____

_____

By signing below, you are attesting that the above information is completed to the best of your ability. Your signature is also consenting to the agreement of the above information.

Signature (1)_____ Date _____

Signature (2)_____ Date _____

Therapist Signature _____ Date _____