Dan Harold, LCSW, CADC I

Couples Intake Form

Date:

Partner Name: Gender: DOB:

Partner Name: Gender: DOB:

Phone:

Address:

Please Circle the Following Symptoms/Concerns either shared or individual:

Decreased Energy	Sad Mood	Forgetful
Obsessive Thinking	Increased Appetite	Inattention
Decreased Sleep	Decreased Appetite	Easily Angered
Difficulty w/ work	Difficulty w/Organization	Restless
Easily Distracted	Unable to Concentrate	Racing Thoughts
Pressured Speech	Exposure to Traumatic Event	Irritable
Difficulty Concentrating	Addiction Concerns	Recent Move
Family Conflict	Communication	Arguing w/Others
Losing Temper	Financial Stress	Excessive Worry
Fearful of Being Alone	Chronic Pain	Alcohol Issues
Intimacy Concerns	Narcotics Issues	Decreased sex drive
Decrease Interest in Activities	Feelings of Worthlessness	Fatigue
Feeling Hopelessness	Panic Attacks	Excessive Fears
Other Addictions	Anxious	History of Trauma

Family Information

Home Address:

_____

Home Phone: _____

Others living in home (Please include Name/Age/Relationship):

1. _____
   ____
2. _____
   ____
3. _____
   ____
4. _____
   ____
5. _____
   ____
6. _____
   ____

Additional Reasons For Seeking Counseling

If needed, Please provide a brief description of your concerns:

_____
_____
_____
_____
_____
_____

Counseling History

Have you sought couples counseling previously?

If yes, dates of service(s):

Where did you receive those services:

_____

Have either of you ever been hospitalized for mental health reasons?

If yes, dates and reasons for hospitalization(s):

_____
_____
_____
_____

Medical Information

#1 Primary Care Physician: Phone:

Address:

_____

Current Medications:

Date of Last Physical Exam:

_____

#2 Primary Care Physician: Phone:

Address:

Current Medications:

Date of Last Physical Exam:

Are there any medical concerns that impact the marraige?

_____

Significant medical history (illnesses, accidents, etc.):

_____
_____
_____
_____

Were there any developmental concerns for either of you during the first 3 years of your life?

_____
_____
_____
_____

Additional Information

Please add any additional information that would be helpful to know in serving you:

_____
_____
_____
_____

_____
_____

Emergency Contact Information

Name: _____ Phone: _____

Name: _____ Phone: _____

INSURANCE

Do you plan to use Insurance for billing? YES NO

If yes, please include the account information below:

INSURANCE PLAN NAME: _____

INSURANCE PLAN #:_____

Please tell me anything at all that I am not asking for, that you think would help me in my work with you. Use the space below as needed: