



## TRAVERSE COUNSELING AND CONSULTING

*Traverse: To pass over, along or through*

### ADULT INTAKE FORM (COUPLE)

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) (MI)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_

Address: \_\_\_\_\_  
(Street and Number) (City) (State) (Zip)

Clinician you are seeing today: \_\_\_\_\_ Soc. Sec.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please note: Email correspondence is NOT considered a confidential medium of communication.

#### Relationship Status: (please circle any that apply)

Never Married  Domestic Partnership  Married  Separated  Divorced  Widowed

\_\_\_\_\_  
Previous Spouse/Partner Age: \_\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_

Year of Marriage: \_\_\_\_\_ If Divorce or Separation date of Divorce/Separation: \_\_\_\_\_

\_\_\_\_\_  
Current Spouse/Partner Age: \_\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_

#### Children:

Child#1: \_\_\_\_\_ Age: \_\_\_\_\_ Child#3: \_\_\_\_\_ Age: \_\_\_\_\_

Child#2: \_\_\_\_\_ Age: \_\_\_\_\_ Child#4: \_\_\_\_\_ Age: \_\_\_\_\_

#### Employment:

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street and Number) (City) (State) (Zip)

Who referred you to Traverse Counseling & Consulting (if any)?: \_\_\_\_\_



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Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) (MI)

My Partner's name: \_\_\_\_\_ We have been in relationship for: \_\_\_\_ year(s) \_\_\_\_ month(s)

While some of the following questions may not seem important or pertinent, this questionnaire is an invitation to reflect on your health, your relationships, and the challenges that you are experiencing. We ask that you spend a little time reflecting on these questions and provide the completed questionnaire *directly to your therapist*. Answering the questions helps the therapist(s) that will be supporting you to know and understand your experience with added depth. We are so honored that you have invited us to support you on your journey.

### GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

- Poor       Unsatisfactory       Satisfactory       Good       Very good

Please list any specific health problems you are currently experiencing: \_\_\_\_\_

\_\_\_\_\_

2. How would you rate your current sleeping habits? (please circle)

- Poor       Unsatisfactory       Satisfactory       Good       Very good

Please list any specific sleep problems you are currently experiencing: \_\_\_\_\_

\_\_\_\_\_

3. How many times per week do you generally exercise?: \_\_\_\_\_

In what types of exercise to you participate?: \_\_\_\_\_

\_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating patterns: \_\_\_\_\_

\_\_\_\_\_

5. Have you ever been diagnosed with a medical condition?:  Yes  No \_\_\_\_\_

\_\_\_\_\_



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6. Are you currently experiencing feeling (check if applicable):

- Overwhelmed       Sadness       Grief       Loss       Depression

For approximately how long? \_\_\_\_\_

7. Are you currently experiencing:  Anxiety     Panic Attacks     Phobias

If yes, how long/describe?: \_\_\_\_\_

8. Are you currently experiencing any chronic pain?:  No  Yes

If yes, please describe \_\_\_\_\_

9. Do you drink alcohol?:  No  Yes If yes, drinks per week:  1-3     4-7     8-14     15-21     21+

10. Medication/Drugs: Have you *ever* been prescribed psychiatric medication?:  Yes  No

Are you *currently* taking any prescribed psychiatric medication?:  Yes  No

If yes, what medication(s)? \_\_\_\_\_

How often do you use *non-prescription* drugs?:  Daily     Weekly     Monthly     Infrequently     Never

Describe your use: \_\_\_\_\_

Do you use tobacco/vaping?  Yes  No

Describe your use: \_\_\_\_\_

11. How would you describe your sleep? \_\_\_\_\_

- Enough       Too much       Wake up frequently       Always tired       Well rested

12. How would you describe your digital life? Your relationship to your cell phone, internet, video games, computer, social media, etc.: \_\_\_\_\_

12. What significant life changes or stressful events have you experienced recently: \_\_\_\_\_



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13. Have you previously received any type of mental health services (psychotherapy, psychiatric services, marriage counseling, etc.)?:  **No**  **Yes**

Previous therapist/practitioner(s): \_\_\_\_\_

\_\_\_\_\_ Was this a positive experience for you?  **No**  **Yes**

Previous goals of therapy: \_\_\_\_\_

### COUPLE RELATIONSHIP:

1. What has happened in your relationship that caused you to seek out couples therapy?:

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2. What have you done in the past to attempt to address the issue(s)?: \_\_\_\_\_

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3. If you have children, what role do they play in your couple relationship, decision to stay married, or decision to divorce?: \_\_\_\_\_

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4. Are there things in your couple relationship that have been difficult to discuss?  **No**  **Yes**

If yes, you may elaborate here, and/or discuss with your therapist: \_\_\_\_\_

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5. My partner/spouse and I are *not aligned* around:  **Money**  **Religion**  **Sex**  **Parenting**  **Other**

Describe: \_\_\_\_\_

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### EXENDED FAMILY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

- Accidental Death                    yes/no \_\_\_\_\_
- Alcohol/Substance Abuse        yes/no \_\_\_\_\_
- Alzheimer's/Dementia            yes/no \_\_\_\_\_
- Anxiety                                yes/no \_\_\_\_\_
- Cancer                                 yes/no \_\_\_\_\_
- Chronic Illness                    yes/no \_\_\_\_\_
- Depression                         yes/no \_\_\_\_\_
- Divorce/Separation                yes/no \_\_\_\_\_
- Domestic Violence/Abuse        yes/no \_\_\_\_\_
- Eating Disorders                  yes/no \_\_\_\_\_
- Head injury/trauma                yes/no \_\_\_\_\_
- Obesity                                yes/no \_\_\_\_\_
- Schizophrenia                      yes/no \_\_\_\_\_
- Suicide and/or Attempts         yes/no \_\_\_\_\_

Other family issues: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What role do extended family play in your couple relationship, decision to stay married, or decision to divorce, and in your couple dynamic?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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### ADDITIONAL INFORMATION:

1. Are you currently employed?  **Yes**  **No** If yes, what is your current employment situation:

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Do you enjoy your work?  **Yes**  **No**

What is most stressful about your current work? \_\_\_\_\_

2. Do you consider yourself to be spiritual or religious?  **No**  **Yes**

If yes, describe your faith or belief: \_\_\_\_\_

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3. What do you consider to be some of your strengths?: \_\_\_\_\_

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4. What do you consider to be some of your growth areas?: \_\_\_\_\_

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5. What are your most important values: \_\_\_\_\_

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6. What is it that makes you feel *stuck*?: \_\_\_\_\_

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7. What would you like to accomplish out of your time in couples therapy?: \_\_\_\_\_

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