Lacamas Counseling & Psychiatry
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LACAMAS COUNSELING & PSYCHIATRY

INTAKE INFORMATION - COUPLES

CONTACT INFORMATION & DEMOGRAPHICS

Full name: _____ **Date:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email address: _____ **Phone:** _____

Check mark approved communication: □Voicemail □Text □Email

DOB: _____ **Age**: _____ **Sex:** □**Male** □**Female** □_____

Gender Identity: _____ **Preferred Pronouns:** _____

Race/Ethnicity: _____

Occupation or previous occupation: _____

Spiritual/Religious Beliefs: _____

Emergency Contact Name & Phone: _____

Partner's name: _____

Relationship Status: _____

Length of time in current relationship: _____

What do you hope to accomplish through counseling?

_____

_____

_____

What have you already done to deal with the difficulties?

_____

_____

What are your biggest strengths as a couple?

_____

_____

Rate your current level of relationship happiness (1 = extremely unhappy; 10 = extremely happy) _____

List your top three concerns that you have in your relationship with your partner:

_____

_____

_____

Have you received prior couples counseling related to any of the above problems? What was the outcome?

_____

_____

Have either you or your partner been in individual counseling before? What concerns were addressed?

_____

_____

Has either of you threatened to separate or divorce as a result of the current relationship problems?

_____

_____

Have either you or your partner struck, physically restrained, used violence against, or injured the other person?

_____

_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

_____

_____

Do you perceive that either you or your partner has withdrawn from the relationship?

_____

_____

If married, have either you or your partner consulted with a lawyer about divorce?

_____

_____

How frequently have you had sexual relations during the last month? _____

How satisfied are you with the frequency of your sexual relations?
(1 = extremely unsatisfied; 10 = extremely satisfied) _____

How would you describe the communication between you and your partner?

_____

_____

Describe any pertinent family history, abuse or trauma

_____

_____

FAMILY

Who lives with you:

Name	Age	Relationship

Who else is significant and/or supportive in your life:

Name	Age	Relationship

What else would you like me to know:

_____

_____

_____

_____

Check any of the following symptoms that have impacted you in the last six months

Depressed Mood
Tiredness/Fatigue
Low energy
Tearfulness
Hopelessness
Apathy/Lack of care
Loss of interest/pleasure
Low self-worth
Low motivation
Isolation from others
Difficulty concentrating
Racing thoughts
Lack of confidence
Increased appetite
Decreased appetite
Irregular sleeping
Anxiety
Panic
Fear
Social anxiety
Panic attacks
Thoughts of harming another person
Suicidal thoughts
Self-harm
Guilt/Shame
Inconsistent mood changes
Excessive Energy
Impulsivity
Compulsive Behaviors
Obsessions
Hear/see things others do not
Paranoia/Suspicion
Reckless Behaviors
Exposure to traumatic event
Flashbacks (while awake)
Nightmares
Avoidance of trauma reminders
Easy startle reflex
Irritability/Anger
Frequent anger outbursts
Other symptoms _____

What stressors/changes have recently impacted you?

Burnout/Stress
Excessively busy
Relocation/Recent move
Career/Job
Retirement
Unemployment
Medical/health
Legal matters
Finances
Finding meaning & purpose
Identity
Religion/spirituality
Parenting difficulties
Divorce/Separation
Grief/Loss
Sexual abuse/rape
Emotional abuse/control
Physical abuse
Residual problems from childhood abuse
Alcohol/drugs
Post-partum transitions
Infertility/Miscarriages
Abortion
Social life
Extended family
Chaotic life
Something else _____

How are these symptoms and stressors affecting your every day life?

Personally _____
Family _____
Friendships _____
Social life _____
Work/School _____
Every day tasks _____