Stephanie Sachs, LLPC Psychotherapist
Comprehensive Psychotherapy & Family Services, PLLC
EIN 91-1385183
NPI 1710315148
LIC#6401013950

950 E Maple Rd; Suite L2
Birmingham, MI 48009
248-703-9249

Couples Counseling Intake Form

Demographics

Name:_____ Date: _____

Address: _____ City:_____State:_____Zip:_____

County:_____ Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: **Phone** or **Email** (circle one)

Couple Information: *Please list those who will be present for counseling*

Name: _____ Age: _____ DOB: _____ Religious Affiliation: _____

_____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (how long ___) **Divorced** (how long ___) **Widowed**

Name: _____ Age: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (how long ___) **Divorced** (how long ___) **Widowed**

Children: *If children are stepsiblings or partial siblings please indicate next to their name*

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Mental Health:

- Has anyone in the immediate family currently or historically been suicidal? (if so who and when?)

  _____

- Has anyone in the immediate family ever been hospitalized for mental health related issues?

  _____

- Is anyone in the immediate family currently receiving counseling services with another professional? If so who and for how long?

  _____

1) What is the primary concern or issue that led you to decide to seek therapy?

_____

_____

2) Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? If yes for either, who, how often and what substances are used? _____

3) Has anyone in the family ever struck, physically restrained, used violence against or injured any other person within the family? (If yes, please explain) _____

_____

4) Have either of you considered separating or divorce as a result of the current marital problems? If so, when?

_____

5) List some strengths in your relationship.

Partner 1: _____

Partner 2: _____

6) List some weaknesses in your relationship.

Partner 1: _____

Partner 2: _____

7) How would you know that your time in therapy has been successful? What looks different in your relationship?

_____

_____

Partner 1: Circle any problem that pertains to you at the present:		
Anger	Education	Sexual Problems
Work	Drug Use	Loneliness
Relationship	Fatigue	Ambition
Stomach Problems	Finances	My Appearance
Suicidal Thoughts	Fears about the Future	Friends
Concentration	Nightmares	Temper
My thoughts	Parenthood	Health Problems
Age	Nervousness	Ability to Relax
Making Decisions	Stress	Self-esteem
Sexual Orientation	Sexual Desire	Sexual Satisfaction
Physical Abuse	Anxiety	Separation
Energy	Feeling of Inferiority	Appetite
Sexual Abuse	Children	Career Choices
Weight	Shyness	Legal Matters
Self-Control	Memory	Sleep
Under / Over-eating	Alcohol Use	Unhappiness
Depression	Headaches	Fears
Other: _____		

Partner 2: Circle any problem that pertains to you at the present:		
Anger	Education	Sexual Problems
Work	Drug Use	Loneliness
Relationship	Fatigue	Ambition
Stomach Problems	Finances	My Appearance
Suicidal Thoughts	Fears about the Future	Friends
Concentration	Nightmares	Temper
My thoughts	Parenthood	Health Problems
Age	Nervousness	Ability to Relax
Making Decisions	Stress	Self-esteem
Sexual Orientation	Sexual Desire	Sexual Satisfaction
Physical Abuse	Anxiety	Separation
Energy	Feeling of Inferiority	Appetite
Sexual Abuse	Children	Career Choices
Weight	Shyness	Legal Matters
Self-Control	Memory	Sleep
Under / Over-eating	Alcohol Use	Unhappiness
Depression	Headaches	Fears
Other: _____		

Circle everything that has happened to you in the past three years:	**Circle everything that has happened to you in the past three years:**
Death of a spouse/partner Relationship Problems Changes in relationship status Death of another family member Family Problems (Children, in-laws) Loss of Job Major illness or injury–yourself Financial Problems Move to another city or state Major illness or injury–family member Legal Problems Other: _____	Death of a spouse/partner Relationship Problems Changes in relationship status Death of another family member Family Problems (Children, in-laws) Loss of Job Major illness or injury–yourself Financial Problems Move to another city or state Major illness or injury–family member Legal Problems Other: _____

Referred by: _____

Emergency contact information:

Name _____

Relationship: _____ **Phone:** _____

Client Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____