THE HOPE CONNECTION

5319 SW Westgate Dr. ste 113
Portland, OR 97221

COUPLES COUNSELING INTAKE FORM
Please Print

Personal Information

Name:			Age:	Gender:
Date of Birth / /				
Address:			Work Phone #:	
City:	State:	Zip:	Home Phone#:	
How did you hear about us?			Cell Phone#:	
Wedding Date:			e-mail address:	

Please indicate below the best times and phone numbers where we can reach you.
Please indicate any restrictions you may have on phone messages:

_____

_____

_____

Emergency Contact Information

Name:		Relationship:	
Address:	City:	State:	Zip:
Home Phone #:	Work Phone #:		
Cell Phone #:	e-mail address:		

Education / Employment Information

Last grade completed in School:	Are you currently employed? ☐ Yes ☐ No
Present Occupation:	Company Name:
Main occupation during past 5 years:	

Relationship History:
How long have you been in the current relationship? _____

How did you meet? _____

_____

_____

Have you ever been separated or previously divorced from your current partner? _____

_____

Have you been married before? ☐ Yes ☐ No I Yes, how many times? _____

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Have you ever had an: ☐ Abortion ☐ Miscarriage
Dates: _____
List everyone currently living in your home:

Name	Age	Birthdate	Relationship	Occupation

What sorts of problems are you currently experiencing in the relationship? Please be specific (communication about money, disagreements over childrearing, etc.) _____
_____
_____

Have you previously sought help for these problems outside of your extended family? If so, what kind of help have you engaged? (religious or couples counseling) _____
_____
_____

Has anything helped resolve the problem? _____
_____
_____

Has anything intensified the problem? _____
_____
_____

What would describe your daily relationship with each other? Check one.
☐ Cool and distant ☐ Heated and argumentative ☐ Friendly and comfortable

How often do you engage in sexual relations? _____

Family History:
Who did you live with until you were 18 years of age? _____
_____

Mother's current age ____ If deceased, her age at death? _____your age at time of her death?____

Father's current age ____ If deceased, his age at death? _____ your age at time of his death? ____

Did your parents ever divorce? ☐ Yes ☐ No

If yes, how old were you at the time of your parents divorce? _____

Did you have a stepparent before you were 18 years of age? ☐ Yes ☐ No
Were you adopted? ☐ Yes ☐ No If yes, at what age? _____

Do you have adopted siblings? ☐ Yes ☐ No If yes, at what age? _____

Were you ever in foster care or a similar living situation? ☐ Yes ☐ No

If yes, at what age? _____ for how long?_____

Medical History:
Are you presently being treated for any health problems? ☐ Yes ☐ No

What prescribed medications do you take? _____
_____
_____

What over the counter (non prescription) or herbal medications do you take? _____
_____
_____

Physician's name _____ Phone # _____

How would you rate your health?
☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Do you or your family members currently have or have ever had any of the following:

Please check all that apply

	Now	Past	Family		Now	Past	Family		Now	Past	Family
Asthma				Immune System Problems				Tuberculosis			
Heart Disease				Chronic Fatigue Syndrome				Epilepsy			
Headaches				Head Injury				High Blood Pressure			
Digestive Disorders				Arthritis				Thyroid Disorder			
Cancer				Vision Problems				Multiple Sclerosis			
Diabetes				Hearing Problems				Pregnancy			
Breathing Problems				Fibromyalgia				Stroke			
Alcohol or Drug Abuse				Depression				Other			

Have you ever taken any of the following?

Please check all that apply and list dates if possible

Substance	✓	Dates	Substance	✓	Dates
Antidepressants			Methamphetamines		
Tranquilizers			Pain Medication		
Anti-psychotic Medicine			LSD or other hallucinogens (mushrooms)		
Alcohol			Heroin		
Cocaine/Crack			Sleep Medication		
Stimulants			Sniffing Inhalants		
Ecstasy			Other		

How much and how often do you consume alcohol?
☐ I do not drink ☐ Rarely ☐ Occasionally ☐ Frequently

Are you in a recovery program? ☐ Yes ☐ No If yes, which program? _____

Do you smoke marijuana? ☐ Yes ☐ In the Past ☐ No
If yes, how often? _____

Do you use nicotine? ☐ Yes ☐ No
If yes, how many packs a day and for how long? _____

Have you ever had a problem with gambling? ☐ Yes ☐ In the Past ☐ No

Do you have problems sleeping? ☐ Yes ☐ No

Do you have problems with eating or with food? ☐ Yes ☐ No
If yes, please describe: _____
_____

Psychological History:
Have you ever been to in counseling before? ☐ Yes ☐ No
If yes, where and with whom? _____

How helpful was it? **Please circle one**

1- - - - - - - - - - - - - -2- - - - - - - - - - - - - -3- - - - - - - - - - - - - -4- - - - - - - - - - - - - -5

Positive | Somewhat Positive | Neutral | Somewhat Negative | Negative

Did anyone in your family die before you were 18 years old? ☐ Yes ☐ No
If yes, who, and how old were you? _____

Other family deaths? _____
_____

Have you ever been hospitalized for a mental illness? ☐ Yes Year _____ ☐ No

Have you ever been diagnosed with a mental illness? ☐ Yes Year _____ ☐ No

If yes, please explain: _____
_____

Has a family member been diagnosed/hospitalized with a mental illness? ☐ Yes Year _____ ☐ No
If yes, please explain: _____
_____

Have you been abused or assaulted? ☐ Yes ☐ No ☐ Don't Remember
Did you witness abuse between your parents? ☐ Yes ☐ No ☐ Don't Remember
Did you witness abuse between parent and child? ☐ Yes ☐ No ☐ Don't Remember
Have you had suicidal thoughts in the past 2 months? ☐ Yes ☐ No

Have you considered suicide as an option in the past 2 months? ☐ Yes ☐ No

Do you have a suicide plan? ☐ Yes ☐ No
If yes, what is it? _____
_____

Have you ever attempted suicide? ☐ Yes ☐ No
If yes, how many times? _____ When and how? _____
_____

Has anyone in your family ever attempted or succeeded at suicide? ☐ Yes ☐ No
If yes, who? _____

Have you ever had any legal issues (criminal or civil)? ☐ Yes ☐ No
If yes, please explain what the issue was and when you had it. (example: DUI, divorce, identity theft, etc.)
_____
_____
_____

Do you have any friends or family with whom you discuss your deepest problems? ☐ Yes ☐ No
Who? _____

How many friends or family members do you have with whom you talk on a regular basis?
Daily (or nearly daily) _____ Weekly _____ Monthly _____

Describe any important values, beliefs, religious training, and/or traditions

_____

_____

_____

_____

Please list three goals you hope to accomplish through counseling:

1. _____

2. _____

3. _____

Signature_____ Date _____

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