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Beljan Psychological Services
Psychotherapy Couple's Intake Form

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____Employment: _____

Home Address: _____ City_____ ST ____Zip_____

Phone: HM:_____ C: _____

Email: _____

Person who referred you: _____

Information

Spouse/ Partner Name: _____

Age:_____

Education: _____ Occupation: _____

Number of children and ages:_____

Others living with you:_____

You are: single married separated divorced re-married widowed

Spouse/ Partner Name: _____

Age:_____

Education: _____ Occupation: _____

Number of children and ages:_____

Others living with you:_____

Referral Information

Briefly describe the main reasons you are seeking services.

_____

What have you tried to address the concern?

_____

_____

What worked best? _____

_____

What has not worked? _____

_____

_____

What do you hope to will happen through this process? _____

_____

_____

Who lives in the household with you?

_____

_____

Mental Health History

PARTNER A: (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicidal Ideation	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive Disorder	Personality Disorder

Other: _____ Other: _____ Other: _____ Other: _____

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____

PARTNER B: (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicidal Ideation	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive Disorder	Personality Disorder
Other: _____	Other: _____	Other: _____	Other: _____

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____

Please list current and past psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/ Occupation	**Dates Seen**	**For What?**	**Describe Progress**

Family History of Both Partners (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicide/	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive	Personality Disorder
Suicidal Ideation		Disorder	
Other: _____	Other: _____	Other: _____	Other: _____

Please explain:

_____

_____

_____

_____

_____

Couple's Background

Has you or the couple experienced: (circle all that apply):

death of a loved one	separation from a loved one	emotional trauma	sexual abuse
family conflict	marital conflict	physical abuse	emotional abuse
domestic violence	suicidal ideation	self-injurious behaviors	neglect
complications with birth		infertility	adoption

Current members of the household and religious preference: _____

_____

Describe relationship history (current and past)

:

_____

_____

_____

Describes social outlets and supports:

_____

_____

Areas of improvement:

_____

_____

_____

Major transitions (moving, schools, death/loss, divorce, etc).:

_____

_____

_____

Please add any additional information you would like us to know:

_____

_____

_____