momentum
mental health

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Couples Intake Form

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy. **Please print out this form and bring it completed to your first session OR allow yourself thirty minutes prior to your appointment to complete the form in the office.**

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Spouse/Partner's Name: _____
(Last) (First) (Middle Initial)

Local Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) _____ Cell/Other Phone: ( ) _____

Work Phone: ( ) _____ E-mail: _____

May we call and leave messages at home? □ Yes □ No On your cell? □ Yes □ No At work? □ Yes □ No
May we email you? □ Yes □ No

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Marriages: _____ Date of Current Divorce/Separation: _____

Medical History

How would you rate your current physical health? □ Excellent □ Good □ Fair □ Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)? Do you have chronic medical conditions or learning disabilities? If yes, please list: _____

_____

_____

Daily Medication(s)	Prescribing Physician

Family Physician: _____ Phone: _____

Have you been previously prescribed psychiatric medication?

□Yes □No If Yes, please list: _____

4. Are you having problems with your sleep habits? □ No □ Yes If yes, check all that apply:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other _____

5. How many times per week do you exercise? _____ Approximately how long each time? _____

6. Have your appetite or eating habits changed? □ No □ Yes If yes, check all that apply:
□ Eating less □ Eating more □ Binging □ Restricting

7. How often do you use alcohol? □ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Do you smoke? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

If you engage in recreational drug use, what are your drug(s) of choice: _____

Personal and Family Mental Health History

1. Have YOU ever experienced:

Extreme depressed mood: □ No □ Yes
Wild Mood Swings: □ No □ Yes
Extreme Anxiety: □ No □ Yes
Homicidal Thoughts: □ No □ Yes
Suicide Attempt: □ No □ Yes
Self Injurious Behavior: □ No □ Yes
Panic Attacks: □ No □ Yes
Phobias: □ No □ Yes
Sleep Disturbances: □ No □ Yes
Hallucinations: □ No □ Yes
Rapid Speech: □ No □ Yes
Unexplained losses of time: □ No □ Yes
Unexplained memory lapses: □ No □ Yes
Sexual Addictions: □ No □ Yes
Alcohol/Substance Abuse: □ No □ Yes
Memory Loss or Dementia: □ No □ Yes
Frequent Body Complaints: □ No □ Yes
Eating Disorder: □ No □ Yes
Body Image Problems: □ No □ Yes
Repetitive Thoughts (e.g., Obsessions) : □ No □ Yes
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) : □ No □ Yes

2. Have you had previous counseling, psychiatric services or psychotherapy? □No □Yes

If yes, previous therapist's name _____

3. Have you ever had suicidal thoughts in the past? □No □Yes Have you had any recently? □No □Yes

Do you have them today? □No □Yes Have you ever been hospitalized for suicidal thoughts? □No □Yes

4. Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member(s)**
Depression: □ No □ Yes	_____
Bipolar Disorder: □ No □ Yes	_____
PTSD: □ No □ Yes	_____
Anxiety Disorders: □ No □ Yes	_____
Panic Attacks: □ No □ Yes	_____
Schizophrenia: □ No □ Yes	_____
Alcohol/Substance Abuse: □ No □ Yes	_____
Eating Disorders: □ No □ Yes	_____
Learning Disabilities: □ No □ Yes	_____
Trauma History: □ No □ Yes	_____
Suicide Attempts: □ No □ Yes	_____

Reasons for Seeking Help

What concerns have brought you to counseling today? _____

_____

When did these concerns begin to be a problem for you? _____

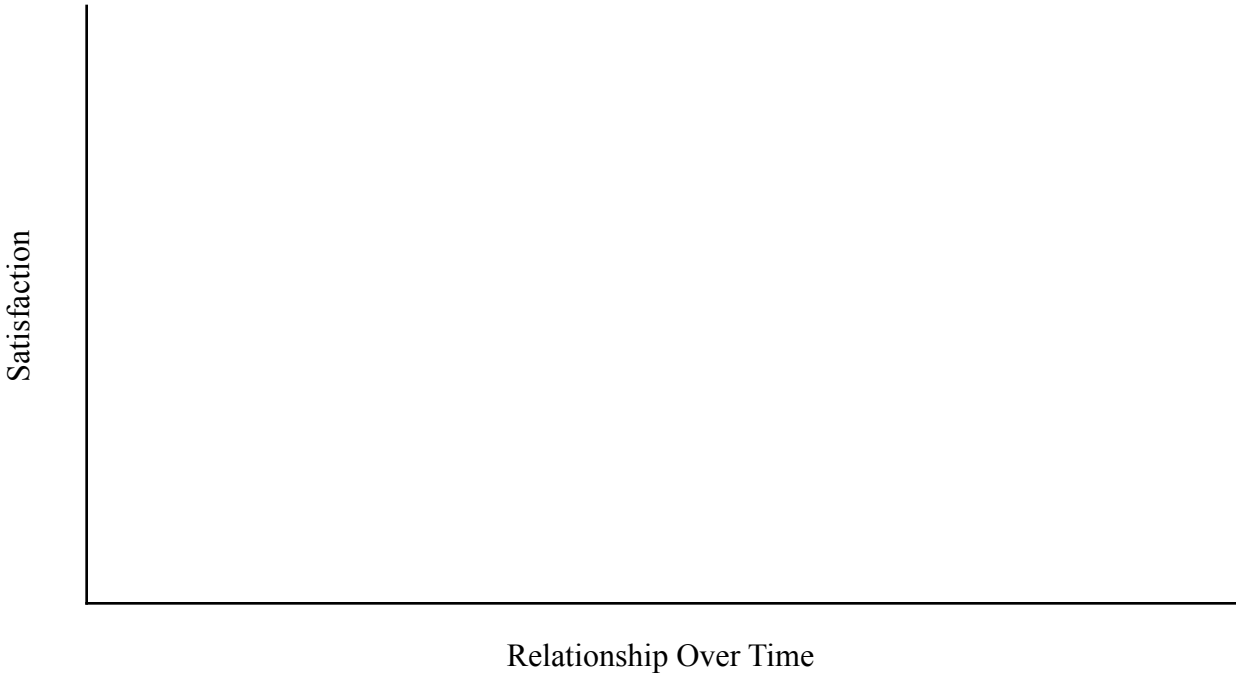
On a scale of 1-10, how would you rate the quality of your current relationship? _____

Why? _____

On a scale of 1-10, how would you rate the quality of your sexual relationship? _____

Why? _____

Please draw a graph indicating your level of marital satisfaction beginning with when you met your partner. Note pivotal events in your relationship



Please make one suggestion as to something you could personally do to improve the marriage regardless of what your partner does:

_____

Have either or you threatened to separate or divorce as a result of the current marital problems (Or have either of you filed for divorce)? □ No □ Yes

What are the biggest areas of contention/disagreement between you and your spouse? _____

_____

What are your goals for your marriage, and/or what are your goals for seeking counseling? _____

_____

Occupational Information:

Are you currently employed? □ No □ Yes

If yes, please list current employer and position? _____

If yes, are you happy at your current position? □ No □ Yes

Please list any work-related stressors, if any: _____

Religions/Spiritual Information:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

Other Information:

Is there anything else you would like me to know today? _____

_____

_____

How Did You Hear About Momentum Mental Health? _____