Thrive Counseling Center
Couples' Client Intake Form (one for each partner)

Date _____

Client information:
Client's Name _____
Client's Age_____Client's Date of Birth_____
Address _____
Preferred Phone Number _____
OK to call _____ OK to leave message _____OK to text_____
Email address_____
OK to email (for billing and session reminder) _____
Occupation _____
Employer _____ Length of time _____
Marital status _____ If married, how long _____
List everyone living in your house and their ages_____
_____
Church affiliation (if any)
_____
Referred by
_____

Medical/Mental Health history:
Medical problems _____
Medications you are taking_____
Alcohol use/abuse_____

Previous counseling experience:
Name of counselor/facility Dates Reason treated
_____ _____ _____
_____ _____ _____
Was counseling helpful for you? Why or why not?_____
_____

What made you decide to seek out counseling this time?

_____

_____

What are your goals for counseling?

_____

_____

List any past or previous events that you feel would be helpful for me to know (abuse, relationship or work issues, traumatic events, illness):

Circle any symptoms that you are experiencing:

Depression Anxiety Loneliness Sleep too much

Can't sleep Crying spells Nervousness Anger outburst

Jealous Loss of energy Confusion Suspicious

Increased sex drive Oversensitive Headaches Loss of appetite

Fears or Phobias Hallucinations Decreased sex drive

Work Problems Suicidal thoughts Trouble getting along with others

Briefly describe the issue(s) you circled:

_____

_____

_____

_____

Current relationship:

1. What are the things you like most about your relationship?

2. What do you like most about your partner?

3. What are the things you most want to change about your relationship?

4. How often do you argue? What do you most often argue about?

5. Anything else about your relationship you wish to share?