RELATIONSHIP INSIGHTS
therapy & coaching

INTAKE FORM

Please print out this form and bring it to your first session.

****

Contact Information:

Your name: _____ Today's date: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

E-mail: _____

Best time and way to reach you: _____

If some kind of emergency arises and I need to reach someone close to you, whom should I call?

#1 Name: _____

Phone: _____ Relationship: _____

#2 Friend or relative not residing with you _____

Phone: _____ Relationship: _____

History:

1. Are you currently employed? ❑ No ❑ Yes Who is your current employer? _____

What is your position? _____

2. What is your romantic relationship status? ❑ Married ❑ Separated ❑ Divorced ❑ Single ❑ Engaged ❑ Remarried ❑ Widowed ❑ Partnered/Significant Other ❑ Cohabiting ❑ Beginning New Relationship

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

4. What are some of the challenges you are facing in your current relationship? _____

_____

_____

5. Have you had previous therapy before? ❑ No ❑ Yes If so, what did you find helpful? _____

_____

Unhelpful? _____

6. Are you on any medications? ❑ No ❑ Yes If yes, what? _____

7. Any stressors in the past 12 months? _____

_____

_____

8. What are your goals for therapy? _____

_____

_____

Chief Concern:

Please briefly describe the issue(s) that brought you to counseling, and what concerns you the most right now:

_____

_____

_____

Please check any of the concerns that apply or have applied to you:

__ 1. Depressed mood
__ 2. Crying spells
__ 3. Sleep difficulties
__ 4. Difficulty with motivation
__ 5. Irritability
__ 6. Mood swings
__ 7. Weight loss or gain
__ 8. Anxiety or panic attacks
__ 9. Perfectionistic thinking
__ 10. Eating Disorders
__ 11. Body Image
__ 12. Problems with anger
__ 13. Unwanted habits
__ 14. Self harm (cutting, burning)
__ 15. Past physical/sexual abuse
__ 16. Alcohol / Substance Abuse
__ 17. Trouble with memory
__ 18. Confusion
__ 19. Unusual thoughts
__ 20. Gambling
__ 21. Impulsivity
__ 22. Obsessive thought/behavior
__ 23. Phobias / fears
__ 24. Easily distracted
__ 25. Difficulty completing tasks
__ 26. Relationship problems
__ 27. Sexual concerns
__ 28. Sexual addiction
__ 29. Grief / Loss
__ 30. Concerns with parenting
__ 31. Work-related concerns
__ 32. Problems with school
__ 33. Legal problems
__ 34. Money management
__ 35. Health problems
__ 36. Recent health issues
__ 37. Muscular tension / headaches
__ 38. Menstrual difficulties
__ 39. Infertility
__ 40. Suicidal thoughts (past)
__ 41. Suicidal thoughts (present)
__ 42. Other (specify) _____

Relationship Satisfaction

If you are in a relationship please rate it in the following areas, on a scale of 1-10 (10 being most satisfied):

____ Communication
____ Conflict Management
____ Sex & Physical Intimacy
____ Life / Work Balance
____ Spirituality / Faith
____ Parenting
____ Household Duties
____ Social Life (As Couple)
____ Social Life (As Individual)
____ Finances
____ Outside Support
____ Roles

How did you hear about us?

❑ Psychology Today; ❑ Good Therapy; ❑ Theravive; ❑ Twin Cities Therapists; ❑ Internet or Google Search

What phrase did you use in your search: _____

❑ Person: _____ Permission to thank? ❑ No ❑ Yes ____ (Please Initial)

What drew you to Relationship Insights and the therapist that you chose? _____

_____

_____

Would you like to receive our Relationship Insights Newsletter? ❑ No ❑ Yes _____ (Please Initial). *It's filled with great tips, to-do's and helpful information about relationships, and you can always unsubscribe if you change your mind*.

We appreciate you taking the time to fill out this form. Thank you!!