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Licensed Psychologist

COUPLE INTAKE QUESTIONNAIRE

Today's Date: _____

A. Names:

Partner 1._____

Partner 2._____

B. Living Arrangements:

□ Live just as a couple □ Live separately and alone □ Others live in our home(s):

Name: Age: Relationship: Living With:	Name: Age: Relationship: Living With:	Name: Age: Relationship: Living With:	Name: Age: Relationship: Living With:

Name: Age: Relationship: Living With:	Name: Age: Relationship: Living With:	Name: Age: Relationship: Living With:	Name: Age: Relationship: Living With:

C. Communication:

Partner 1

Phone _____ _____ _____ _____
(home) (cell) (work) (other)

e-mail: _____

May we leave messages for you? □ on home phone □ on work phone □ by email □ other _____

□ Do not leave messages

Partner 2

Phone: _____ _____ _____ _____
(home) (cell) (work) (other)

e-mail: _____

May we leave messages for you? □ on home phone □ on work phone □ by email □ other _____

□ Do not leave messages

D. Emergency contacts:

Partner 1. _____Phone: _____Relationship: _____

Partner 2. _____Phone: _____Relationship: _____

E. Referred by: _____

Continue on next page

Names:
Date:

COUPLE INFORMATION

THE MAIN PROBLEMS

Describe the problem(s) that brought you here today:

Symptoms that either of you are having: Check in column					
Partner	#1	#2	Partner	#1	#2
Depression			Feeling hopeless		
Extreme sadness			Feeling tearful		
Trouble concentrating			Change in sleeping habits		
Memory problems			Lack of energy		
Change in eating habits			Weight changes		
Feeling of extreme happiness			Change in sexual interest or function		
Trouble performing your job			Problems getting along with friends or family		
Lack of enjoyment of usual activities			Feeling stressed		
Self-esteem problems			Easily irritated		
Perfectionism			Feeling guilty		
Obsessions or compulsions			Feeling nervous		
Feeling fearful			Sudden feelings of panic		
Physical complaints of pain			Muscle tension		
Problems with anger			Acting violently		
Thoughts of hurting yourself or others			Thoughts of killing yourself or others		

This space reserved for additional comments by Dr. Johannsen:

Names:
Date:

COUPLE INFORMATION

HAVE YOU EVER BEEN IN COUNSELING BEFORE? Yes ☐ No ☐

If you have been in counseling before, please describe it below. Start with the most recent time first.

A. When did you last have counseling?	Date(s):
What was your counselor's name?	
Was it individual (if so, which partner) or couple focused? Explain what happened:	
B. When did you have counseling before that?	Date(s):
What was your counselor's name?	
Was it individual (if so, which partner?) or couple focused? Explain what happened:	

F. Background Information:

	Education	Occupation	Employer
Partner 1			
Partner 2			

MEDICAL INFORMATION

Have you seen a physician within the last year?

Partner 1 Yes ☐ No ☐

Partner 2 Yes ☐ No ☐

If yes, why did you seen a physician?

Partner 1:

Partner 2:

Who are your physicians?

Partner 1 Phone:

Partner 2 Phone:

Names:
Date:

COUPLE INFORMATION

Are you taking any medications, prescription or over-the-counter?

Partner 1 **Yes** ☐ **No** ☐

What medications?	How much?	How often?	What reason?
1.			
2.			
3.			

Partner 2 **Yes** ☐ **No** ☐

What medications?	How much?	How often?	What reason?
1.			
2.			
3.			

Do you have allergies to anything?

Partner 1: Yes ☐ No ☐

Partner 2: Yes ☐ No ☐

Describe allergy problems that you have:

Partner 1:

Partner 2:

SUBSTANCE USE HISTORY

PARTNER 1

Do you use/ have you used tobacco (any form)?	Current ☐	Past ☐	No ☐
Do you use/ have you used alcohol?	Current ☐	Past ☐	No ☐
Do you use/ have you used caffeine (any form, including cola drinks)?	Current ☐	Past ☐	No ☐
Do you use/ have you used other mind-altering substances (drugs)?	Current ☐	Past ☐	No ☐

Names:
Date:

COUPLE INFORMATION

PARTNER 2

Do you use/ have you used tobacco (any form)?	Current ☐	Past ☐	No ☐
Do you use/ have you used alcohol?	Current ☐	Past ☐	No ☐
Do you use/ have you used caffeine (any form, including cola drinks)?	Current ☐	Past ☐	No ☐
Do you use/ have you used other mind-altering substances (drugs)?	Current ☐	Past ☐	No ☐

ANY ADDITIONAL INFORMATION THAT WILL BE HELPFUL: