COUPLES INTAKE ASSESSMENT FORM

STOKAN JAGGERS & ASSOCIATES
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Please answer all of the following questions to the best of your ability.

IDENTIFYING INFORMATION

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ Cell phone: _____
Is it OK to contact you at home? ☐ Yes ☐ No OK to leave a message? ☐Yes ☐ No
Special calling instructions?☐ Yes ☐ No _____

OCCUPATION/EMPLOYMENT INFORMATION

Check all that apply: ☐ employed ☐ retired ☐ disabled ☐ student
☐ homemaker ☐ unemployed
If/When employed, what type of work do you do?

_____

Are you currently having difficulties on the job?☐ Yes ☐ No
If yes, please explain: _____

_____

HEALTH/MEDICAL INFORMATION

How is your current physical health? (please check)

☐Poor ☐Fair ☐Satisfactory ☐Good ☐Very good

Please list any significant medical problems/conditions, and indicate if you are receiving treatment for them:

_____
_____
_____
_____

Do any of these problems affect your everyday life? ☐Yes ☐No If yes, how?

_____
_____

Have you ever had a serious head injury? ☐Yes ☐No If so, please describe:

_____

List all medications that you currently use:

Please list any "alternative" therapies/treatments you are currently using and the reason for each:

Please check any symptoms you are currently or have recently experienced:

Depression: ☐
Racing Thoughts: ☐
Panic Attacks: ☐
Sleep Disturbances: ☐
Unexplained losses of time: ☐
Poor Concentration: ☐
Eating Disorder: ☐
Repetitive Thoughts (Obsessions): ☐
Loneliness:☐
Stress: ☐
Anger: ☐
Rapid Speech: ☐
Feeling Worthless: ☐
Indecisiveness: ☐
Intrusive Memories: ☐
Vocal or Motor Tics: ☐
Guilt: ☐
Aggression: ☐
Extreme Mood Swings: ☐
Anxiety: ☐
Phobias: ☐
Hallucinations: ☐
Unexplained Memory Lapses: ☐
Frequent Body Complaints: ☐
Body Image Problems:☐
Repetitive Behaviors:☐
Low Self Esteem: ☐
Impulsive Behaviors: ☐
Fears:☐
Sadness:☐
Unmotivated: ☐
Grief ☐
Spiritual Problems: ☐
Startled Easily: ☐
Fatigue: ☐
Other: ☐_____

SUBSTANCE USE HISTORY

Have you ever experienced a problem with alcohol, drugs, or prescription medications?
☐Yes ☐No
If yes, please explain

INTERESTS AND ACTIVITIES

Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are currently involved in:

_____

_____

_____

Please describe your personal strengths and characteristics:

_____

_____

_____

_____

RELATIONSHIP QUESTIONS

Name of Spouse: _____

Marital/Relationship Status (Check one):

☐Married/Committed ☐ Separated ☐Divorced ☐Dating
☐Living Together ☐Living Apart

Length of time in current relationship: _____

Is monogamy an expectation in your relationship: _____

Children (Including biological, adopted, foster, step):

Name	Sex	Age	Type	Custody

Please check any of the reasons listed below that resulted in your request for therapy. (If appropriate, specify self or partner)

_____ Depression or Anxiety _____
_____ Alcohol/Drug Abuse _____
_____ Marital Problems _____
_____ Communication Difficulties _____
_____ Extramarital Affair/Relationship _____
_____ Improve Sexual Relations _____
_____ Child/Parent Conflict _____
_____ Divorce Counseling _____
_____ Sexual Orientation Questions _____
_____ Suicidal Thoughts _____
_____ Homicidal Thoughts _____
_____ Difficulty with Loss or Death _____

_____ Relationship Enhancement _____
_____ Abuse (Physical/Mental) _____
_____ Medical/Physical Problem _____
_____ Pre-Marital Counseling _____
_____ Other _____

What is the primary issue that you are dealing with in your relationship?

How long have you had this issue?

Have you had similar issues in past relationships?

Why are you seeking help NOW?

Have you received couples therapy in the past? _____ Yes _____ No
If yes, when and with whom? _____

What was the outcome? _____

What are your greatest strengths as a couple?

What would you like to see happen as a result of therapy?

Check the statement(s) below that describe the type of family you grew up in:

☐ overly close family	☐ no "breathing room"	☐ no privacy
☐ boundaries not respected	☐ comfortably close family	☐ loving
☐ many positive experiences	☐ supportive	☐ distant
☐ not much time spent together	☐ not a lot of support	
☐ angry, lots of fight ng/hostility	☐ verbal abuse and conflicts	☐ violence
☐ frightening	☐ scared to make mistakes	

☐ other descriptors: _____

What do you consider to be the other stresses in your life?

_____

_____

_____

_____

Other information you feel is important and wasn't asked:

_____

_____

_____

_____

Thank you for your time and cooperation