Bluegrass Family Therapy, LLC

Couples Therapy Intake Form

Your Name: _____ Your DOB: _____
First Middle Last

Address _____ City_____ Zip_____

Occupation: _____ Employer:_____

Education Level (circle one): HS Bachelor Master Doctorate

Number of Marriages: _____ Your Gender (circle one): M F

Home Phone: _____ OK to leave message? Y N
Cell Phone: _____ OK to leave message? Y N
Work Phone: _____ OK to leave message? Y N

Spouse's / Partner's Name: _____ DOB: _____
First Middle Last

Address _____ City_____ Zip_____

Occupation: _____ Employer:_____

Education Level (circle one): HS Bachelor Master Doctorate

Number of Marriages: _____ Your Gender (circle one): M F

Home Phone: _____ OK to leave message? Y N
Cell Phone: _____ OK to leave message? Y N
Work Phone: _____ OK to leave message? Y N

Relationship Status (check one): ____Single ____Married ____Divorced ____Committed Relationship

Do you reside together? _____Y _____N

How long have you been together as a couple? _____

Have you ever separated? _____Y _____N

Please list below all children from this or previous marriages/relationships. (include biological, adopted & step children living in your household or not)

Name	Age	Gender	Relationship	Do you have custody?
_____	____	_____	_____	□ Yes □ No
_____	____	_____	_____	□ Yes □ No
_____	____	_____	_____	□ Yes □ No
_____	____	_____	_____	□ Yes □ No
_____	____	_____	_____	□ Yes □ No

Briefly describe why you are seeking therapy:

_____

_____

_____

_____

Previous Counseling (self) _____Y _____N

If yes, please provide therapist's name, dates and reason for seeking therapy:

_____

_____

Have you ever been hospitalized for a mental health

Previous Counseling (partner) _____Y_____N

If yes, please provide therapist's name, dates and reason for seeking therapy:

_____

_____

Have you ever been hospitalized for a mental health

Medical History (Self):

Current Health Problem	Treating Physician	Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any past health problems that have significantly impacted your relationships?

_____

Medical History (Partner):

Current Health Problem	Treating Physician	Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any past health problems that have significantly impacted your relationships?

_____

Who referred you?

_____	Doctor / Psychiatrist	_____	Mental Health Professional
_____	School	_____	Court
_____	Friend	_____	Employer
_____	Internet	_____	Attorney