



# Community Counseling Services

Therapist: Dezaree Finch

Please fill out the following couples intake information as completely as possible. Thank you.

Date: \_\_\_\_\_

Your Name: \_\_\_\_\_ Partner/Spouse Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security # \_\_\_\_\_ Social Security # \_\_\_\_\_

Single  Married  Date \_\_\_\_\_ Divorced  Date \_\_\_\_\_ Widowed  Date \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Children:	<u>Full Name</u>	<u>Age</u>	<u>Living at home? (Y/N)</u>
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Emergency Contact (Name/Phone): \_\_\_\_\_

How were you referred to me/us? \_\_\_\_\_

Previous Counseling: (Who? When? How long? Outcome?)  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatric Hospitalization or Rehab: (Dates) \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Current Medications: \_\_\_\_\_ Amounts: \_\_\_\_\_

\_\_\_\_\_ Amounts: \_\_\_\_\_

\_\_\_\_\_ Amounts: \_\_\_\_\_

Reason(s) for seeking counseling:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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Your Name: \_\_\_\_\_

### Additional Questions for Couples

**Thank you for taking the time to let me know a little about you in order to better serve your needs and achieve your goals. One of the ways to do this is by asking you some background information. You can answer very briefly just to give me an idea of some things that are important. Thank you for your time.**

What ethnic cultural background do you associate with?: \_\_\_\_\_

What do you hope to accomplish in therapy?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is the highest grade you completed?: \_\_\_\_\_

Do you have any religious and/or spiritual beliefs?: \_\_\_\_\_

Does anyone in your family have any known mental disorders/challenges? Any treatment?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you or anyone in your family ever used any kinds of drugs, including alcohol?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any current use by you or your family?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was your relationship like with your family growing up?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Your Name: \_\_\_\_\_

Was there any violence: physical, emotional, sexual, and psychological abuse that has happened with you or anyone else in your family?: \_\_\_\_\_

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Have you or anyone in your family attempted to kill themselves or harm themselves in anyway? Any current thoughts of suicide?: \_\_\_\_\_

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Have you been in any situation that resulted in your arrest or conviction for a crime?: \_\_\_\_\_

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Have you had a recent medical and dental evaluation? Were there any problems indicated? Any past problems in your past medical and dental history?: \_\_\_\_\_

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Do you see or hear things that other people do not see or hear?: \_\_\_\_\_

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Has there been any type of cheating in this relationship? If yes, by who?: \_\_\_\_\_

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