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Couples' Information/Intake

Names:_____Date:_____

Phones:_____ _____

Address:_____

_____

Emails: _____ _____

Dates of Birth & Ages: _____ _____

Person to notify in case of emergency:_____

Their Contact phone: _____

Each of you please take a moment to discuss your reasons for seeking therapy at this time and your goals for therapy:

Medications: Are either of you taking any medications? Please list:

Do either of you smoke? If so, how long, how many and how often?

Do either of you drink? If so, how long, how many, what kind of alcohol and how often?

Do either of you do recreational drugs? If so, how long, how often, and which drugs?

If you had a magic wand and you could change ONE THING about YOURSELF, what would it be?

If you had a magic wand and you could change ONE THING about YOUR PARTNER, what would it be?

Thank you for taking the time to fill this out as honestly and openly as possible.