SOUND INSIGHT
COUNSELING

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COUPLES/FAMILY INTAKE FORM
and CONSENT FOR TREATMENT
(Please bring this completed form to your first session
or mail it to me at the address above)

Section I ~ Personal Information - Partner A

Name: _____
Phone number (Cell/Home): _____
May I leave a voicemail message on this phone? Y / N
Address: _____
Email: _____
Would you like to receive appointment reminders via email? Y/N
Age: _____ DOB: _____ Gender: _____
Ethnicity/cultural ties: _____
Is your spiritual affiliation important to you? Y/N
If so, what is your spiritual affiliation? _____
Occupation/Profession: _____
Employer/School: _____
Relationship Status: (please circle one):
Single/Dating/Engaged/Married/Separated/Divorced
Do you have children? Y/N
What are their names, ages and do they reside with you?
_____
_____

Please list any current health issues (or attach additional sheet):
_____
_____
_____

Medications (including dosage and diagnosis):
_____
_____
_____

Primary Care Provider: _____
Phone number: _____
May I contact your doctor to coordinate care? Y/N
Current Individual Therapist (if applicable): _____
Phone number: _____
May I contact this therapist to coordinate care? Y/N
(Partner A continued)
Family history of mental health issues or substance abuse?

_____
_____

Personal history of emotional, physical, sexual abuse or trauma? Y/N
If yes, could you briefly describe type and age it occurred?

_____
_____
_____

Personal Information - Partner B:

Name: _____
Phone number (Cell/Home): _____
May I leave a voicemail message on this phone? Y / N
Address: _____
Email: _____
Would you like to receive appointment reminders via email? Y/N
Age: _____ DOB: _____ Gender: _____
Ethnicity/cultural ties: _____
Is your spiritual affiliation important to you? Y/N
If so, what is your spiritual affiliation? _____
Occupation/Profession: _____
Employer/School: _____
Relationship Status: (please circle one):
Single/Dating/Engaged/Married/Separated/Divorced
Do you have children? Y/N
What are their names, ages and do they reside with you?

_____
_____

Please list any current health issues (or attach additional sheet):

_____
_____
_____

Medications (including dosage and diagnosis):
_____
_____
_____

Primary Care Provider: _____
Phone number: _____
May I contact your doctor to coordinate care? Y/N
Current Individual Therapist (if applicable): _____
Phone number: _____
May I contact this therapist to coordinate care? Y/N
(Partner A continued)
Family history of mental health issues or substance abuse?
_____
_____

Personal history of emotional, physical, sexual abuse or trauma? Y/N
If yes, could you briefly describe type and age it occurred?
_____
_____
_____

Section 2 ~ Joint Information:

How long have you known each other? _____
If you are engaged or married, what was/is the date of wedding? _____
If you are separated, when did this occur? _____

What are the issue(s) leading you both to seek counseling at this time?

Partner A:
_____
_____
_____
Partner B: _____
_____
_____

When do you believe the issue(s) began?
Partner A: _____
Partner B: _____
What solutions have you tried and how well have they worked?
_____
_____

What goals do you both hope to achieve through counseling?
Partner A: _____
_____
_____
Partner B: _____
_____
_____
What are some of the ways we would know you have achieved those goals?
_____
_____

Have you ever gone to counseling before (either alone or together)? Y/N
When and with whom? _____
_____
_____
If you are comfortable doing so, please briefly describe the topics you covered in your previous counseling: _____
_____
_____
How helpful was your previous counseling experience and why?
_____
_____
Are there any events in your family histories or facts about your families that you believe would be helpful for me to know regarding the issues you would like to address?
_____
_____

Section 3 ~ Assessment of Risk

Have either of you experienced any of the following now or in the past?
If you circle Y on any of these below, please indicate which partner experienced this in the space to the right and include date.

- Previous psychiatric hospitalization Y/N
- Mental health diagnosis Y/N
- DUI/Arrests Y/N
- Chemical or alcohol dependency Y/N
  - If yes, which chemical and how often do you use per week now? _____
  - How many drinks do you have per week now? _____
- Other types of addictive behavior: _____
- Suicide attempts Y/N
- Cutting or disordered eating Y/N
- Domestic violence (physical, emotional, sexual) Y/N
- Feelings of hopelessness Y/N

- Recent loss Y/N
- Family history of suicide Y/N
- Recent traumatic events Y/N
- Childhood traumatic events Y/N
- Obsessive/compulsive behavior Y/N

Would you say that either of you are currently at risk of harming yourself, one another or another person? Y/N (please circle one)

If so, please describe this risk and ways you may be able to reduce this risk:

_____

Section 4 ~ Consent for Treatment

We, _____, and _____ do hereby give our consent to undergo treatment for the issues listed above with Cindi S. Whalen, MS, LMFT of Sound Insight Counseling PLLC. We understand that Cindi Whalen will work with us on our listed goals, but that ultimately reaching these goals is our sole responsibility. We understand that different issues may come up in the midst of attaining our goals and that these goals may be reassessed or changed during the counseling process. We have read, understood, and signed the Disclosure Statement that provides information regarding laws relevant to the counseling process, our financial responsibilities and our rights as clients.

_____

Partner A signature Date

_____

Partner B signature Date

_____

Cindi S. Whalen, MS, LMFT Date
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