Couples Intake Form

Paul Duke, MA, LMHC
Whole Person Counseling

902 Market Street
Tacoma, WA 98402

6626 Wagner St. NW
Gig Harbor, WA 98335

WholePersonGHTacoma@gmail.com
(206) 317-1898

Today's date:________

Name:____Date of birth:__________Age:_______

Address:____

____

Landline Phone:______________________. Voice message OK? Yes___ No___

Cell Phone:_______________________. Voice message OK? Yes___ No___

Text message OK? Yes___ No___

Email address:____________________________. Okay to use for scheduling? Yes___ No___

Occupation:____

Education:____

Religious affiliation, if any:____

Ethnic/ racial/ national/ indigenous heritage:____

Other way you identify yourself that is important to you:________________________________

Have you ever received counseling, psychiatric, or drug or alcohol treatment before? Y__ N__
If yes, please explain: ____

____

____

Please list any physical health problems or disabilities of any kind you currently have and how long you have had them: ____

____

____

____

Name of partner:____

If living together, how long? ______________ If married, how long? ______________

If there are children from this relationship, please indicate:
Name___________________ Gender____ Age____
Name___________________ Gender____ Age____
Name___________________ Gender____ Age____
Name___________________ Gender____ Age____

If previously married, please indicate:

Name of Spouse	Years Married	Date Marriage Ended	Reason
______________	_________	________________	___________________________
______________	_________	________________	___________________________

If there are children by previous marriage or relationship, please indicate:
Name___________________ Gender____ Age____
Name___________________ Gender____ Age____
Name___________________ Gender____ Age____
Name___________________ Gender____ Age____

If any brothers and sisters, including those deceased, please indicate:

Name	Age	Gender	Education	Occupation	Marital Status
_________	___	____	_______	________	__________
_________	___	____	_______	________	__________
_________	___	____	_______	________	__________
_________	___	____	_______	________	__________
_________	___	____	_______	________	__________
_________	___	____	_______	________	__________

Father's Name___________________ Birthplace_____________
Education_______________________ Occupation____________
Present Age___ If deceased, when?_______

Mother's Name___________________ Birthplace_____________
Education_______________________ Occupation____________
Present Age___ If deceased, when?_______

Was either parent married more than once? Please give details:
____
____
____
____
____
____

Please answer each question as completely and accurately as possible. Your information will help me learn about your relationship and help me plan your treatment.

1. What are the things you like most about your relationship?

2. What do you like most about your partner?

3. What are the things you most want to change?

4. How often do you argue? What do you most often argue about?

5. Do your arguments get physical? Verbally abusive? Please detail.

6. Do you feel safe and secure with your partner? Now? In the past? Please detail.

7. In your present relationship, can you ask your partner when you need closeness and comfort? Please detail. Please rate your level of difficulty in doing so (1 extremely easy --– 10 extremely difficult).

8. Can you think of bonding moments in your relationship when one of you reaches out and the other responds in a way that makes you both feel emotionally connected and secure with each other? Please detail.

9. Who did you go to for comfort when you were young? Could you always count on this person/ these people for comfort? Did this person/ these people ever betray you, or were they unavailable at critical times? What did you learn about comfort and connection from this person/ these people? Please detail.

10. If no one was safe, how did you comfort yourself?

11. Did you ever turn to alcohol, drugs, sex, or material things for comfort?

12. Were there any not previously mentioned traumatic incidents in your growing up, your previous romantic relationships, or otherwise in your life? Use back of page or extra sheet if needed.

13. Were there significant times in your current relationship when you felt your partner was not there for you? Please detail.

14. If it is hard for you to turn to and trust others, to let them close when you really need them, what do you do when life gets too big to handle or when you feel alone?

15. Name two specific things that would make you feel safer and more secure in your present relationship.

16. Anything else about your relationship you wish to share?

Client Name (please print) ____

Client signature____Date________