FAMILY PSYCHOLOGICAL SERVICES
of Lakeland

COUPLES IN-TAKE ASSESSMENT AND CLIENT INFORMATION

NAME: **DATE COMPLETED:**

DATE OF BIRTH: **AGE:** **GENDER:**

SEXUALITY: **RACE:** **ETHNICITY:**

STREET ADDRESS:

CITY: **STATE:** **ZIP:**

CONTACT PHONE NUMBER: **IS IT OK TO LEAVE A VOICEMAIL? NO YES**

ALTERNATE CONTACT PHONE NUMBER: **IS IT OK TO LEAVE A VOICEMAIL? NO YES**

IS IT OK TO SEND YOU SOMETHING IN THE MAIL? NO YES

EMAIL:

WOULD YOU LIKE TO RECEIVE EMAIL COMMUNICATION? NO YES

HOW WERE YOU INTRODUCED TO US?

HOW HAVE WE COME TO MEET?

WHAT ARE THE THREE BIGGEST CONCERNS YOU HAVE FOR YOUR RELATIONSHIP RIGHT NOW?

1.

2.

3.

WHAT DO YOU THINK THOSE THAT CARE ABOUT YOU WOULD SAY THEIR CONCERN(S) IS/ARE?

WHAT SOLUTIONS HAVE YOU TRIED TO RESOLVE THE PROBLEMS THAT YOU ARE SEEKING THERAPY FOR?

CHANGE IS COMING …

WHAT ARE YOUR EXPECTATIONS FROM THERAPY? THE THERAPIST?

LOOKING INTO THE FUTURE, HOW WILL YOU KNOW THAT OUR WORK AND TIME TOGETHER HAS BEEN WORTH IT? LIST CONCRETE CHANGES YOU WILL SEE:

WHAT OTHER THINGS WOULD YOU LIKE TO SEE CHANGE IN YOUR LIFE? (FAMILY, CAREER, HEALTH, ETC.)

WHAT ARE YOUR PARTNER'S WORRIES, STRESSES, HOPES, DREAMS, AND ASPIRATIONS?

IF YOU COULD DO ANYTHING IN THE WORLD WITHOUT CONCERN OF TIME, RESOURCES, MONEY, WHAT WOULD YOU BE WILDLY PASSIONATE ABOUT DOING?

WHAT DO YOU CURRENTLY DO FOR WORK?

WHO/WHAT WOULD YOU SAY YOUR SUPPORT SYSTEM IS? (PEOPLE, RELIGIOUS, SPIRITUAL, AFFILIATIONS, ETC.)

LIST FIVE STRENGTHS ABOUT YOURSELF AND RELATIONSHIP. GIVE EXAMPLES OF EACH:

1.

2.

3.

4.

5.

Any Current or Past Medical Issues, Hospitalizations, Accidents, Injuries, Allergies, Illnesses, or Surgeries That Impact you Currently?

No Yes If Yes, What?

List Any Medications, OTC and Prescribed, Nutritional or Herbal Supplements, or Alternative Treatments (Acupuncture, Chiropractic, Etc.) You Are Taking/Doing and the Reasons:

In the Past Year, Have There Been Any Changes in Your Life? (Moves, Appetite, Sleep, Health, Family, Overall Functioning, Etc.)

Important Questions We Must Ask

Have Your Ever Thought about Killing Yourself or Not Wanting to be Alive? No Yes If Yes, Please Explain:

Have You Ever Planned to Kill Yourself? No Yes If Yes, Please Explain:

Have You Ever Attempted to Kill Yourself? No Yes If Yes, Please Explain:

Have You Ever Felt Like You Wanted to Seriously Hurt or Kill Someone Else? No Yes If Yes, Please Explain:

Do you have weapons in your home or Access to Weapons? No Yes If Yes, Who has Access to Them and What are the Safety Protocols Around Them?

Is There Any History, Past or Present, of Abuse or Violence? No Yes If Yes, Please Explain:

Are You Currently Using any Illegal Drugs or Is the Reason You are Seeking Therapy Services Substance Abuse Related?

No Yes If Yes, Please Explain:

Have You Ever Witnessed or Experienced a Trauma? Do You Have Reoccurring Nightmares, Flashbacks, or Do You Avoid Anything That is Uncomfortable or Painful? No Yes If Yes, Please Explain:

Intimate Relationship

How Long Have You Been Together? Married?

What Do You Do/Enjoy as a Couple? How Do You Connect on a Daily Basis? (Dinner, Texts, Etc.)

What Do You Do/Enjoy Individually? What Do You Hope and/or Aspire to?

Describe Your Communication, Emotional Intimacy, and Connection in Your Relationship:

Describe Sex in Your Relationship. (The Satisfaction Level, Frequency, How Sex Affects your Relationship, Etc.)

Most Couples Think Betrayals are Affairs, but Betrayals Come In Many Forms in Relationships. Has There Been Any Major Betrayals in Your Relationship That Has Had a Major Affect on You Such As: Constant Lying, Broken Promises, Affairs, Coldness/Distance/Absenteeism, Forming Coalitions (Between You and Another Person or Between Your Partner and Another Person), Withdrawal of Sexual Interest, Disrespect, Unfairness, and Selfishness.

If So, Please Describe:

Answer the Following Regarding Your Relationship:

1. **Like:**
2. **Dislike:**
3. **Not Enough Of:**
4. **Too Much Of:**
5. **Ideal Relationship:**

Check Off the Areas in Your Relationship That You Do Well In or Do Not Want to Change:

	Financial Value/Beliefs/ Philosophies		**Communication**
	Romance		**Sex**
	Friendship		**Parenting Value/Beliefs/Philosophies**
	Emotional Intimacy/Connection		**Trust**
	Shared Goals		**Support**
	Fun		**Dealing With Conflict**
	Feeling Loved and Valued		**Other:**

Check Off the Areas in Your Relationship That You Would Like to Change:

	Financial Value/Beliefs/ Philosophies		**Communication**
	Romance		**Sex**
	Friendship		**Parenting Value/Beliefs/Philosophies**
	Emotional Intimacy/Connection		**Trust**
	Shared Goals		**Support**
	Fun		**Dealing With Conflict**
	Feeling Loved and Valued		**Other:**

UNDERSTANDING YOUR FAMILY AND INFLUENCES

SPACE LEFT FOR THERAPIST TO DRAW GENOGRAM (FAMILY TREE):

HOW WOULD YOU DESCRIBE YOUR UP-BRINGING? AND HOW DOES IT IMPACT YOUR RELATIONSHIP?

DESCRIBE YOUR RELATIONSHIP WITH THE FOLLOWING:

MOTHER:

FATHER:

SIBLING(S) – NAME	AGE	SEX	RELATIONSHIP
CHILDREN(S) – NAME	**AGE**	**SEX**	**RELATIONSHIP**

PLEASE LIST ANYTHING ELSE THAT IS IMPORTANT FOR US TO KNOW ABOUT YOU THAT WOULD ASSIST US IN WORKING WITH YOU TO ACHIEVE YOUR DESIRED RESULTS:

PARENT SIGNATURE: _____ DATE: _____