Couples Intake Form

Date: _____

Patient Information

Name _____ Insurance Carrier? Yes No

Date of Birth _____ Age _____

Address _____
Street City, State Zip Code

Phone ( ) - Email _____

Emergency Contact _____ Phone ( ) -

Referral Source _____

Marital Status _____

Employer _____ Occupation _____

Partner Information

Name _____ Insurance Carrier? Yes No

Date of Birth _____ Age _____

Address _____
(if different) Street City, State Zip Code

Phone ( ) - Email _____

Emergency Contact _____ Phone ( ) -

Referral Source _____

Marital Status _____

Employer _____ Occupation _____

Insurance Information

Insurance Co _____

Member ID _____ Group # _____

Have you attended couples therapy previously? If so, please describe (benefits, reason for seeking another professional).

_____

_____

_____

_____

Describe your current living situation (living together/ apart, children, caring for parents).

_____

_____

_____

_____

Children

Name	Age	Natural/ Step/ Half	Describe relationship (favors one parent, open to both)