Ground and Path Contemplative Psychotherapy

W. Trent Schmiedehaus, LCSW-S, SEP

COUPLES INTAKE INFORMATION

Today's Date: _____ Referred By:_____

Is it okay for me to thank the referral source? _____

PARTNER #1

Please provide the following information, which will remain CONFIDENTIAL in accordance with Texas state law. You may omit any question that does not apply.

_____
Full Name Nickname

_____
Address City, State, Zip

_____
Cell Phone Email

_____
Date of Birth Age Gender

_____
Occupation Employer/School Part/Full Time?

_____
Current and Previous Mental Health Issues, Problems and/or Diagnoses

_____
Hospitalizations? Current and Previous Suicide Attempts/Feelings?

_____
Current and Previous Substance Use/Abuse?

_____
Arrests, Legal Troubles or Domestic Violence?

_____
Names of Current or Previous Therapist(s) and Dates Seen

_____

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Names and Dosages of Any Medication you are Taking

When was the Last Time Your Medications were Revisited/Checked?

Family Physician's Name | Psychiatrist's Name

Current or Previous Physical Diseases or Limitations

Current Physical or Nutritional Concerns

Other Relevant Information You Would Like Me to Know About You

PARTNER #2

Please provide the following information, which will remain CONFIDENTIAL in accordance with Texas state law. You may omit any question that does not apply.

Full Name | Nickname

Address | City, State, Zip

Cell Phone | Email

Date of Birth | Age | Gender

Occupation | Employer/School | Part/Full Time?

Current and Previous Mental Health Issues, Problems and/or Diagnoses

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Hospitalizations? Current and Previous Suicide Attempts/Feelings?

Current and Previous Substance Use/Abuse?

Arrests, Legal Troubles or Domestic Violence?

Names of Current or Previous Therapist(s) and Dates Seen

Names and Dosages of Any Medication you are Taking

When was the Last Time Your Medications were Revisited/Checked?

Family Physician's Name Psychiatrist's Name

Current or Previous Physical Diseases or Limitations

Current Physical or Nutritional Concerns

Other Relevant Information You Would Like Me to Know About You

RELATIONSHIP

Marital/Commitment Status Length of Time Together Living Together?

If have Children, Please List their Names, Ages, and Primary Place of Residence

Any Other Persons or Relatives Living in your Home?

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Name of Nearest, Close Relative, his/her Relationship to You, and Phone Number

Please check any of the following items that concern you individually or as a couple:

_____ Self-esteem, self-confidence

_____ Affairs (ongoing or concluded)

_____ Anxiety, nervousness, fears

_____ Depression

_____ Sexual concerns

_____ Angry, hostile feelings

_____ Traumatic experiences

_____ Physical distress

_____ Eating or appetite problems

_____ Alcohol or drug problems

_____ Sleep problems

_____ Parent-child problems

_____ Spiritual/existential issues

_____ Family conflicts or pressures

_____ Friendship conflicts

_____ Shyness, being assertive

_____ Loneliness

_____ Procrastination or motivation

_____ Money/financial issues

_____ Suicidal feelings or behaviors

_____ Stress

_____ Self-control

_____ Health problems

_____ Work or career concerns

Please put a SECOND check next to those that are of particular concern to you right now.

Anything not noted in the list above? _____

Please describe the main concerns that bring you here:

_____

_____

_____

_____

_____

Any additional concerns about your relationship?:

What are your goals for couple therapy? What would you like to see changed, different or improved?

The information I have provided above is current and accurate to the best of my knowledge. I understand that knowingly providing false information may result in denial or termination or services, as well as any legal remedies that may apply.

PARTNER # 1 Signature Date

PARTNER # 2 Signature Date