Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 E, I-30 Suite 100, Greenville, TX 75401
Phone: 903-274-4140; Fax: 877-310-9115

COUPLE'S INTAKE PAPERWORK

Separate forms to be completed by each party

Client's name: _____ Date: _____

Gender: ____F ____M Date of birth: _____ Age: ____ SSN: _____

Form completed by _____

If you need more space for the following questions, please use the back of the sheet.
Primary reason(s) for seeking services:

____ Anger management ____ Anxiety ____ Coping ____ Depression

____ Addictive behaviors ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

____ Sleeping problems ____ Eating disorder____ Alcohol/drugs ____ Hyperactivity

____ Other mental health concerns (specify): _____

EMOTIONAL/PSYCHIATRIC TREATMENT HISTORY

Information about (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric:	___	___	_____	_____	_____
Treatment:	___	___	_____	_____	_____
Suicidal thoughts/attempts:	___	___	_____	_____	_____
Drug/alcohol treatment:	___	___	_____	_____	_____
Hospitalization:	___	___	_____	_____	_____

Diagnosis _____Treatment Beneficial? _____

Has a family member had outpatient psychotherapy? Yes _____ No _____
If yes, who/why (list all): _____

Current prescribed medications	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has any family member used psychotropic medications? Yes_____ No _____

If yes, who/why (list all): _____

Behavioral/Emotional

Please check any of the following that are typical for you:

____Affectionate
___Aggressive
___Alcohol Problems
___Angry
___Anxiety
___Blinking, Jerking
___Bizarre Behavior
___Careless, Reckless
___Chest Pains
___Clumsy
___Cooperative
___Confident
___Cyber Addiction
___Depression
___Destructive
___Difficulty Speaking
___Dizziness
___Drugs Dependence
___Eating Disorder
___Enthusiastic
___Excessive Masturbation
___Expects Failure
___Fatigue
___Fearful
___Frequent Injuries
___Frustrated Easily
___Gambling
___Generous
___Hallucinations
___Heart Problems
___Hopelessness
___Hurts Animals
___Irritable
___Impulsive
___Lazy
___Lies Frequently
___Listens to Reason
___Loner
___Low Self-Esteem
___Messy
___Moody
___Often Sick
___Over Active
___Over Weight
___Panic Attacks
___Phobias
___Poor Appetite
___Psychiatric Problems
___Sad
___Selfish
___Sexual Addiction
___Sick Often
___Short Attention Span
___Shy, Timid
___Sleeping Problems
___Slow Moving
___Speech Problems
___Suicidal Threats
___Suicidal Attempts
___Teeth Grinding
___Tics or Twitching
___Unsafe Behaviors
___Unusual Thinking
___Weight Loss
___Withdrawn
___Worries Excessively
Other:_____

Please describe any of the above (or other) concerns: _____

Medical/Physical Health (check all that apply to your health)

___Abortion
___ Anemia
___Asthma
___Blackouts
___Blindness
___Bronchitis
___Cerebral Palsy
___Chicken Pox
___Congenital Problems
___Croup
___Cancer
___Deafness
___Diabetes
___Ear Aches
___Ear Infections
___Eczema
___Encephalitis
___Fevers
___Glandular Problems
___Heart Diseases
___High Blood Pressure
___Kidney Disease
___Mental Illness
___Migraines
___ Multiple Sclerosis
___Nervousness
___Perceptual Motor Disorder
___Seizures
___Spinal Bifida
___Suicide List

Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 E, I-30 Suite 100, Greenville, TX 75401
Phone: 903-274-4140; Fax: 877-310-9115

___Diphtheria ___Mental Retardation
___Dizziness ___Muscular Dystrophy

List any current health concerns:_____
_____

List any recent health or physical changes:_____

_____

Describe any serious hospitalizations or accidents:

Date	Age	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutrition (Define your current nutritional status)

Do you eat Breakfast, Lunch, Dinner, Snacks? Yes_____ No _____

Would you consider your food choices healthy? Yes _____ No _____

Do you have any issues relating to nutrition? Yes _____ No _____

Please explain: _____

_____

Most Recent Examinations (Define any concerns, problems, issues)

Type of Examination	Date of Most Recent Visit	Results
Physical Examination:	_____	_____
Dental Examination:	_____	_____
Vision Examination:	_____	_____
Hearing Examination:	_____	_____

CHILDHOOD (Check corresponding boxes defining your childhood experience)

Present entire childhood: Mother ____ Father____ Stepmother _____ Stepfather _____

Brother(s) _____ Sister(s) _____ Other (specify)_____

Present part of childhood: Mother ____ Father____ Stepmother _____ Stepfather _____

Brother(s) _____ Sister(s) _____ Other (specify)_____

Not present at all: Mother ____ Father____ Stepmother _____ Stepfather _____

Brother(s) _____ Sister(s) _____ Other (specify)_____

Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 E, I-30 Suite 100, Greenville, TX 75401
Phone: 903-274-4140; Fax: 877-310-9115

Parent's History:

Current marital status: Married to each other for ____years;
Separated for ____ years Divorced for ____ years; Please Explain: _____

Describe parents:
Father deceased for ____ years, age of client at father's death
Father Occupation_____
Education Level_____
General Health_____
Father remarried ____ times Father involved with someone else _____
Your relationship with parent __Poor __Average __Good; Please Explain: _____

Mother deceased for ____ years, age of client at mother's death
Mother Occupation_____
Education Level_____
General Health_____
Mother remarried ____ times; Mother involved with someone else_____
Your relationship with parent __Poor __Average __Good; Please Explain: _____

Describe childhood family experience:

____Outstanding Home Environment _____ Normal Home Environment

____Chaotic Home Environment _____Witnessed physical/verbal/sexual abuse toward others

____Witnessed physical/verbal/sexual abuse from others

Age of emancipation from home:_____

Circumstances:_____

_____

Special circumstances in Childhood:_____

_____

IMMEDIATE FAMILY/ RELATIONSHIPS(*Describe your family situation and living arrangements)*

Relationship Status: ____ Never been in serious relationship

____Not currently in relationship ____ Currently in serious relationship

Martial Status:____ Single, never married; Engaged ____ months

Married for ____ years; Divorced for ____ years; Separated for ____ years

Divorce in process ____ months; Live-in for ____ years; Prior marriages self ____ partner____

Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 E, I-30 Suite 100, Greenville, TX 75401
Phone: 903-274-4140; Fax: 877-310-9115

Relationship Satisfaction: ____ Very satisfied with relationship ____ Satisfied

____Somewhat satisfied _____ Somewhat dissatisfied ____ Dissatisfied

____ Very dissatisfied with relationship

Describe any past or current significant issues in intimate relationships:

_____

_____

IMMEDIATE FAMILY CONTINUED

List all persons/family members living in client's household:

Name **Family member**	Age	Gender	Relationship (e.g., grandparent, cousin, foster child)	Quality of Relationship with the Client
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good

Others living in the household			Relationship (e.g., grandparent, cousin, foster child)	
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good

Describe any past or current significant issues in other immediate family relationships:_____

_____

Comments: _____

_____

_____

FAMILY MEDICAL HISTORY (Check all that apply for client)

Is there a history of any of the following in the family:

___Tuberculosis
___Birth Defects
___Emotional Problems
___Diabetes
___Alcoholism
____Drug Abuse
____Alzheimer's Disease/Dementia
Other: _____

___Behavior Problems
___Thyroid Problems
___Cancer
___Mental Retardation
___Heart Disease
___Stroke

SUBSTANCE USE HISTORY (Check all that apply for client)

Family alcohol/drug abuse history: ___ Father ____Mother ____Grandparent(s) -

____Sibling(s) ____Stepparent/live-in ____ Uncle(s)/Aunt(s) ____ Spouse/Significant Other

____Children ____Other _____ Describe: _____

Client's Substance use status: ____No history of abuse ____Active abuse

____Early full remission ____Early partial remission ____Sustained full remission

____Sustained partial remission

Clients Treatment history: Outpatient (ages[s] _____) Inpatient (age[s] _____)

12-step program (age[s] _____) Stopped on own (age[s] _____)

Describe _____

Consequences of substance use (check all that apply):

___Hangovers

___Seizures

___Blackouts

___Overdose

___Binges

___Withdrawal symptoms

___Medication complications

___Tolerance changes

___Loss of control amount used

___Sleep disturbance

___Assaults

___Suicidal impulse

___Relationship conflicts

___Job loss

___Arrest

Other:_____

Substances used (list all):_____

_____

SOCIO-ECONOMIC HISTORY (Check all that apply)

Living Situation:

____ Housing adequate ____Homeless _____Housing crowded

____Dependent on others for housing ____Housing dangerous/deteriorating

____ Living companions dysfunctional

Employment: Where employed_____

____Employed and satisfied ____ Employed but dissatisfied ____ Unemployed

____Coworker conflicts ____Supervisor conflict ____Unstable work history

____Disabled (describe)_____

Feelings about Work:

___Anxious ___Passive ___Enthusiastic ___Fearful

___Eager ___No Expression ___Bored ___Rebellious

___Other (describe):_____

Financial Situation:

_____No current financial problems_____ Large indebtedness

_____Poverty or below-poverty income_____ Impulsive spending

_____Relationship conflicts over finances _____Other(Describe)_____

Social Support System:

_____Supportive network ____ Few friends____ Substance-use-based-friends

_____No friends _____Distant from family of origin

Military History:

____Never in military ____Served in military-no incident ____Served in military with incident

Describe_____

Legal History:

_____No legal problems ____Now on parole/probation ____Arrest(s) not substance-related

____Arrest(s) substance-related ____ Court ordered this treatment

Jail/prison ____ times, total time served: ____

Describe last legal difficulty: _____

_____

Leisure Recreational

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling)

Activity	How often now? (weekly, none, ect.)	How often in the past? (weekly, none, ect.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What activities do you do with your significant other? How important are these activities to you?

_____

_____

_____

What issues do you wish to work on in counseling?

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 E, I-30 Suite 100, Greenville, TX 75401
Phone: 903-274-4140; Fax: 877-310-9115

Which issue is the most important to you?

_____

_____

_____

What do you find yourself having the most difficulty with?

_____

_____

_____

How do you cope with this?

_____

_____

_____

What are two or three things you expect from your significant other? What must you get from him/her to be happy?

_____

_____

_____

What are one or two things about yourself would you like to change or think you need to change?

_____

_____

_____

How do you argue? How do you make up?

_____

_____

_____

Describe your relationship in five years. What do you see? What do you want to see?

_____

_____

_____

Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 E, I-30 Suite 100, Greenville, TX 75401
Phone: 903-274-4140; Fax: 877-310-9115

Any additional information that you believe would assist us in understanding your situation?

_____

_____

_____

What family involvement would you like to see in the therapy? _____

_____

Are you currently suicidal at this time? ___Yes ___No

If Yes, explain: _____

_____

_____