



AUSTIN PROFESSIONAL
— C O U N S E L I N G —

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Couple Client Intake Information (please fill out together)

Today's Date: _____

Referred by: _____

Partner #1

Name Nickname

Address City, State, Zip

Cell Phone E-mail

Date of Birth Ethnic Background Gender

Occupation Employer/School Part or Full Time?

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

Hospitalizations? Current and Previous Suicide Attempts/Feelings?

Current or Previous Substance Use/Abuse?

Arrests, Legal Trouble or Domestic Violence?

(Optional): Name(s) 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

Partner #2

Name

Nickname

Address

City, State, Zip

Cell Phone

E-mail

Date of Birth

Ethnic Background

Gender

Occupation

Employer/School

Part or Full Time?

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

Hospitalizations?

Current and Previous Suicide Attempts/Feelings?

Current or Previous Substance Use/Abuse?

Arrests, Legal Trouble or Domestic Violence?

(Optional): Name(s) 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?

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

Please check any of the following items that concern you:

- | | |
|---|---|
| <input type="checkbox"/> Self-esteem, self-confidence | <input type="checkbox"/> Family conflicts or pressures |
| <input type="checkbox"/> Anxiety, nervousness, fears | <input type="checkbox"/> Friendship conflicts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Relationship/marital concerns |
| <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Shyness, being assertive |
| <input type="checkbox"/> Angry, hostile feelings | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Traumatic experiences | <input type="checkbox"/> Procrastination or motivation |
| <input type="checkbox"/> Physical distress | <input type="checkbox"/> Money/financial issues |
| <input type="checkbox"/> Eating or appetite problems | <input type="checkbox"/> Suicidal feelings or behaviors |
| <input type="checkbox"/> Alcohol or drug problems | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Self-control |
| <input type="checkbox"/> Parent-child problems | <input type="checkbox"/> Health problems |
| <input type="checkbox"/> Spiritual/existential issues | <input type="checkbox"/> Work or career concerns |

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

Please describe the main concerns that bring you here:

Any additional information about your relationship?