SHERRY HELGOE, PsyD, LMFT #38590, LPCC #1642
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Couples Therapy Intake Form

Adults only | In-person and telehealth services

Please complete the Shared Relationship section together. Then each partner should complete their own entire section independently. Partner 1 comes first, followed by Partner 2. Please do not alternate between sections.

Shared Relationship Information

Date: **Relationship status:**

Shared address:

City: **State:** **ZIP:**

Relationship began: **Married/committed since (if applicable):**

Primary scheduling contact: ☐ **Partner 1** ☐ **Partner 2** ☐ **Both**

Preferred contact method: ☐ **Phone call** ☐ **Email**

Children or dependents, including names and ages:

Who currently lives in the home?

What brought you to couples therapy now?

What do you hope will be different as a result of therapy?

What have you already tried?

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Your Relationship Together

What do you each value about the relationship?

What still works between you, even during difficult periods?

When conflict begins, what usually happens next?

How do disagreements usually end?

What helps the two of you repair after conflict?

When do you feel closest to one another?

How would your relationship be different if the concerns that brought you here improved?

Previous Couples Therapy

Have you previously participated in couples therapy? ☐ No ☐ Yes

When: **Length of treatment:**

What concerns were addressed, and what was the outcome?

Previous couples therapist:

How did you hear about the practice? ☐ Internet ☐ Friend/relative ☐ Professional referral ☐ Other:

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Partner 1 - Personal Information

Partner 1: Please complete this entire section yourself before moving on. Partner-specific questions are intentionally kept together.

Legal name: **Preferred name:**

Date of birth:

Phone: **Email:**

May I leave a voicemail that identifies the practice? ☐ Yes ☐ No

Current work, school, caregiving, retirement, or primary role:

What are your personal strengths?

What do you believe is your contribution to the current relationship pattern?

What do you most want your partner to understand about your experience?

Motivation for couples therapy (1-10): **Relationship satisfaction today (1-10):**

What is one thing you could do consistently that might improve the relationship?

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Partner 1 - Current Concerns, Health, and Safety

Please check any current concern or past experience that still affects you:

☐ Anxiety or excessive worry
☐ Depression or low mood
☐ Stress or overwhelm
☐ Anger or irritability
☐ Grief or loss
☐ Loneliness or disconnection
☐ Obsessive or intrusive thoughts
☐ Difficulty sleeping
☐ Difficulty relaxing
☐ Appetite changes
☐ Low self-esteem
☐ Career or work concerns
☐ Life transition
☐ Family or blended-family concerns
☐ Sexual or intimacy concerns
☐ Alcohol or substance concerns
☐ Chronic illness or pain
☐ Spiritual concerns
☐ Other: _____

Anything else you would like me to know about the concerns checked above?

Safety

Have you had thoughts of harming yourself or not wanting to live? ☐ Never ☐ In the past ☐ Recently ☐ Currently

Do you currently feel physically and emotionally safe in the relationship? ☐ Yes ☐ No ☐ Unsure

Has there been violence, threats, intimidation, stalking, controlling behavior, or fear? ☐ No ☐ Yes ☐ Unsure

If yes or unsure, briefly describe what would help me understand the safety concern:

Medical, Medication, and Substance Information

Medical or psychological concerns that may affect therapy:

Primary care physician: **Phone:**

Psychiatrist/prescribing provider: **Phone:**

Are you taking prescribed medications? ☐ No ☐ Yes

If yes, please list medications and purpose:

Do you drink alcohol? ☐ No ☐ Yes

If yes, how often and how much?

Do you use recreational drugs or other substances? ☐ No ☐ Yes

If yes, what and how often?

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Partner 1 - Previous Care and Emergency Contact

Have you participated in individual therapy before? ☐ No ☐ Yes

When: **Length of treatment:**

What concerns were addressed, and was therapy helpful?

Previous therapist:

Are you currently in individual therapy? ☐ No ☐ Yes

Current therapist: **Phone (if known):**

Listing another provider does not authorize me to contact that person. A separate written authorization is required for coordination of care.

Emergency Contact

Name: **Relationship:**

Phone:

Is there anything else you would like me to know before our first session?

Partner 1 completed this section independently: ☐ **Yes**

Partner 1 signature: **Date:**

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Partner 2 - Personal Information

Partner 2: Please complete this entire section yourself before moving on. Partner-specific questions are intentionally kept together.

Legal name: **Preferred name:**

Date of birth: **Pronouns (optional):**

Phone: **Email:**

May I leave a voicemail that identifies the practice? ☐ Yes ☐ No

Current work, school, caregiving, retirement, or primary role:

What are your personal strengths?

What do you believe is your contribution to the current relationship pattern?

What do you most want your partner to understand about your experience?

Motivation for couples therapy (1-10): **Relationship satisfaction today (1-10):**

What is one thing you could do consistently that might improve the relationship?

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Partner 2 - Current Concerns, Health, and Safety

Please check any current concern or past experience that still affects you:

☐ Anxiety or excessive worry
☐ Depression or low mood
☐ Stress or overwhelm
☐ Anger or irritability
☐ Grief or loss
☐ Loneliness or disconnection
☐ Obsessive or intrusive thoughts
☐ Difficulty sleeping
☐ Difficulty relaxing
☐ Appetite changes
☐ Low self-esteem
☐ Career or work concerns
☐ Life transition
☐ Family or blended-family concerns
☐ Sexual or intimacy concerns
☐ Alcohol or substance concerns
☐ Chronic illness or pain
☐ Spiritual concerns
☐ Other: _____

Anything else you would like me to know about the concerns checked above?

Safety

Have you had thoughts of harming yourself or not wanting to live? ☐ Never ☐ In the past ☐ Recently ☐ Currently

Do you currently feel physically and emotionally safe in the relationship? ☐ Yes ☐ No ☐ Unsure

Has there been violence, threats, intimidation, stalking, controlling behavior, or fear? ☐ No ☐ Yes ☐ Unsure

If yes or unsure, briefly describe what would help me understand the safety concern:

Medical, Medication, and Substance Information

Medical or psychological concerns that may affect therapy:

Primary care physician: **Phone:**

Psychiatrist/prescribing provider: **Phone:**

Are you taking prescribed medications? ☐ No ☐ Yes

If yes, please list medications and purpose:

Do you drink alcohol? ☐ No ☐ Yes

If yes, how often and how much?

Do you use recreational drugs or other substances? ☐ No ☐ Yes

If yes, what and how often?

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Partner 2 - Previous Care and Emergency Contact

Have you participated in individual therapy before? ☐ No ☐ Yes

When: **Length of treatment:**

What concerns were addressed, and was therapy helpful?

Previous therapist:

Are you currently in individual therapy? ☐ No ☐ Yes

Current therapist: **Phone (if known):**

Listing another provider does not authorize me to contact that person. A separate written authorization is required for coordination of care.

Emergency Contact

Name: **Relationship:**

Phone:

Is there anything else you would like me to know before our first session?

Partner 2 completed this section independently: ☐ **Yes**

Partner 2 signature: **Date:**

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Shared Acknowledgment

This intake form helps me understand the concerns that bring you to therapy. It is not the Couples Therapy Agreement or No Secrets Policy. We will review those policies separately before treatment begins.

Is there anything the two of you would like to add together?

We understand that each partner completed their own section and that both partners will review and sign the separate informed consent and couples therapy agreement.

Partner 1 signature: **Date:**

Partner 2 signature: **Date:**

Therapist signature: **Date:**

I look forward to working with you.