

CLIENT INTAKE FORM: COUPLES

For therapy services with Jennifer A. Watts, Ph.D., LMFT
25-B Lenox Pointe, N.E., Atlanta, GA 30324

Date _____

GENERAL INFORMATION – please print

Referred by (if internet, which site/s?) _____

If a personal/professional referral, may I thank the person? Yes No

Client 1

Last name _____ First name _____ MI _____

Birth date ____/____/____ Age _____

Street Address _____
(street) (city) (state & zip)

Cell phone _____ preferred ok to leave message?

Home phone _____

Work phone _____

Email address _____

Place of Employment _____ Length of Employment _____

Type of work you do _____

Highest level of education completed: High School College degree Graduate degree
 Professional training Other _____

In case of emergency, contact _____

Relationship _____ Emergency phone _____

Client 2

Last name _____ First name _____ MI _____

Birth date ____/____/____ Age _____ Sex: Female Male

Street Address _____
(street) (city) (state & zip)

Cell phone _____ preferred ok to leave message?

Home phone _____

Work phone _____

Email address _____

Place of Employment _____ Length of Employment _____

Type of work you do _____

Highest level of education completed: High School College degree Graduate degree
 Professional training Other _____

In case of emergency, contact _____

Relationship _____ Emergency phone _____

Relationship status: engaged married partnered living together separated

Length of time married/partnered (or length of relationship): _____

Others living in your home (Names/Relationship/Age): _____

Children not living in your home (Names/Ages): _____

COUNSELING CONCERNS

What is the major problem? Client 1: _____

Client 2: _____

How long have you had this problem? Client 1: _____

Client 2: _____

When else have you had similar problems? Client 1: _____

Client 2: _____

Why are you seeking help now? Client 1: _____

Client 2: _____

What would you like to see happen as a result of therapy? Client 1: _____

Client 2: _____

MEDICAL AND PSYCHOLOGICAL HISTORY

Have you received psychotherapy or counseling in the past? No Yes

If so, when and with whom? _____

Client 1:

List physical illnesses or symptoms: _____

Physician's/Psychiatrist's name(s) and phone number(s): _____

List current medications: _____

Client 2:

List physical illnesses or symptoms: _____

Physician's/Psychiatrist's name(s) and phone number(s): _____

List current medications: _____

Have either of you received help for drug or alcohol dependency?

No Yes Who? _____ When? _____ For what? _____

Where? _____

Have either of you been hospitalized for mental/emotional/psychiatric reasons?

No Yes Who? _____ When? _____ For what? _____

Where? _____

OTHER

Please provide any other information you think will be necessary or helpful: