CLIENT INTAKE FORM: COUPLES For therapy services with Jennifer A. Watts, Ph.D., LMFT
Today's Date _____ 1766-B Century Boulevard, Atlanta, GA 30345

GENERAL INFORMATION – please print
Referred by (if internet, which site/s?) _____

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

Client I
Last name _____ First name _____ MI _____

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

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

	preferred	ok to leave message?
Cell phone _____	❑	❑
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)

	preferred	ok to leave message?
Cell phone _____	❑	❑
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): _____

_____

Check any of the following that apply to you and explain

___ Depression_____

___ Alcohol_____

___ Drug abuse_____

___ Other addictions _____

___ Serious illness _____

___ Violence _____

___ Suicide thoughts _____

Are these currently being treated? yes ____ no ____

By whom? _____

Their phone ( ) _____ May I contact them? yes ___ no ___

Are you currently in therapy? yes ____ no ____

With whom? _____

Their phone ( ) _____ May I contact them? yes ___ no ___

Have you ever been in therapy before? yes ____ no ____

With whom? _____ When? _____

Their phone ( ) _____ May I contact them? yes ___ no ___

How will you know when your couples therapy is successful?

_____

_____

_____

Realistically, how long do you think this might take? _____

Payments and Cancellations

I agree to pay for my treatment at the time of service.
I agree that if I cancel an appointment without sufficient notice, I will pay for the time that was saved for me.

Date _____

Signature _____

Print your name _____

OTHER

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