VIP
VERTEX INTEGRATIVE PSYCHOTHERAPY

Couples Therapy Intake Form

Name: Date:
Address:
City, State:
Zip:
Best phone number to reach you: ( )_____ is it okay to leave a message? ▫Yes ▫No May I text you? ▫Yes ▫No Email:
May I email you? ▫Yes ▫No *Please note: Email and text correspondence is not considered to be a confidential medium of communication.

Birth date: _____ Age: _____
Will you be using insurance?
if you are not the insured, please provide:
Insureds name:
Insureds birthdate:
Insureds address:

General and Mental Health Information
1. How would you rate your current physical health? (Please circle one) Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

What types of exercise do you participate in?

4. Please list any difficulties you experience with your appetite or eating problems:

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long?
6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe:

8. How often do you drink alcohol? About how much alcohol per use?

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Relationship Status:
Do you think about divorce?

What are the things you like most about your relationship?

What are your biggest strengths as a couple?

What are the things you most want to change?

What is one thing that you could personally do to improve the relationship, regardless of your partner making a change?

What is your most frequent argument about?

Do your arguments ever get physical?

How enjoyable is your sexual relationship? (circle one)
1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

How often have you had sexual relations in the past 30 days?

How satisfied are you with the frequency of your sexual relations? (circle one)
1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress? (circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress within the relationship?
1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

Have you ever been in individual therapy? If so, for what issues

Rank the order of the top three concerns you have in your relationship with your partner (1 being the most problematic)
1.
2.
3.

Anything else that you would like me to know?