COUPLES COUNSELING INTAKE FORM

First Name:		Last Name:	
Preferred Name:			
Date of Birth:		Pronouns:	
Gender:		Marital Status:	
Address:			
Email:			
Preferred Phone Number:			
Patient Identifier (If known):			

PARTNER'S INFORMATION

Partner's Name:	
Contact Number:	

HEALTH AND MEDICAL INFORMATION

Primary Care Physician:	
Primary Care Physician Address:	
Primary Care Physician Contact Number:	
Please list any medical conditions:	
Please list any current medications:	

Do you have any allergies? If so, could you please specify what you are allergic to?

INSURANCE INFORMATION (IF APPLICABLE)

Insurance Carrier:	
Insurance Plan:	
Contact Number:	
Policy Number:	
Group Number:	

EMPLOYMENT INFORMATION

Employment Status	
Occupation:	
Company Name:	
Company Address:	
Zip Code:	

YOUR AVAILABILITY THROUGHOUT THE WEEK

CONSENT AND AGREEMENT

I understand that the information I provide on this form will be used for the purpose of my therapy and treatment. I consent to the collection and storage of this information in accordance with applicable privacy laws and regulations.

I acknowledge that therapy services may involve discussions of sensitive and personal topics, and I am prepared to engage in this therapeutic process.

I agree to the terms and policies of [Your Practice Name], including cancellation policies and fees.

Signature:	
Date:	