LifeCare Counseling
Psychotherapy Services Caring for You and Your Life

COUPLES INTAKE FORM

1293 Professional Drive, Suite A-101
Myrtle Beach, SC 29577
843.605.0514 office 843.962.5570 fax
info@mvlifecarecounseling.com

PERSONAL INFORMATION

Primary Client: (Considered Identified Client (Financially Responsible for Billing/Insurance Subscriber)

Name (First, MI, Last)		Birth date (month/day/year)		Age
Home address (number and street)	Apt. no.	City/town		Zip
Phone number where you may be reached and messages left ○ Cell ○ Home ○ Work		Email address		
In emergency, contact:	Phone:	Relationship:		

Spouse/Partner:

Name (First, MI, Last)		Birth date (month/day/year)		Age
Home address (number and street)	Apt. no.	City/town	State	Zip
Phone number where you may be reached and messages left ○ Cell ○ Home ○ Work		Email address		
In emergency, contact:	Phone:	Relationship:		

BILLING INFORMATION

Person responsible for bill (if not the client):			
Birth date:	Home phone:	Cell phone:	
Address (if different):	City:	State:	Zip:

INSURANCE INFORMATION

Do you have insurance?	☐ Yes ☐ No		
Primary Insurance Provider:		Type of Insurance Plan:	
Subscriber's name:			Birth date:
Policy/ID #:	Group #:		
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Subscriber's Occupation:	Employer:		
Employer address:			Employer phone:

SCHEDULING/CONTACT PREFERENCES

Please list your scheduling preferences (Time of Day/Day):			
Appointment Reminders ok by text? ☐ Yes ☐ No	Phone:	Email:	
How did you hear about LifeCare Counseling?	☐ Referral:	☐ Internet	☐ Other:

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Relational/Family Information

Marital status: ☐ Single ☐ Domestic Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If you are in a romantic relationship/marriage/partnership, how long? *(years, months)* _____
On a scale of 1 to 10, (with 10 being best) how would you rate your satisfaction with your relationship? _____
Do you have children? If so, please provide their names and ages, and indicate with who they live:

Name:_____Age:_____ Name:_____Age_____

Name:_____Age _____ Name:_____Age _____

Name:_____Age _____ Name:_____Age _____

List any other individuals living in your home (other than you and any children listed above):

Medical History

Primary Client	Spouse/Partner
Do you have any medical conditions? ○ Yes ○ No If yes, please describe below: __	Do you have any medical conditions? ○ Yes ○ No If yes, please describe below:
_	

Primary Client	Spouse/Partner
Do you take any medications? ○ Yes ○ No If yes, list Rx, Dose, Length Taken & Reason Prescribed __	Do you take any medications? ○ Yes ○ No If yes, list Rx, Dose, Length Taken & Reason Prescribed
_	

Primary Client	Spouse/Partner
Who is Your Primary Care Provider:	Who is Your Primary Care Provider:

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Family History

Primary Client	Spouse/Partner
Is there a family history of chronic illness or medical conditions (i.e. heart disease, diabetes, etc.)? ○ Yes ○ No If yes, please describe below: __	Is there a family history of chronic illness or medical conditions (i.e. heart disease, diabetes, etc.)? ○ Yes ○ No If yes, please describe below:
_	

Primary Client	Spouse/Partner
Is there a family history of mental health conditions (i.e. anxiety, depression, etc.)? ○ Yes ○ No If yes, please describe below: __	Is there a family history of mental health conditions (i.e. anxiety, depression, etc.)? ○ Yes ○ No If yes, please describe below:
_	

Primary Client	Spouse/Partner
Is there a family history of substance abuse? ○ Yes ○ No If yes, please describe below: __	Is there a family history of substance abuse? ○ Yes ○ No If yes, please describe below:
_	

Primary Client	Spouse/Partner
Do you have a history of trauma/loss from your family of origin? ○ Yes ○ No If yes, please describe below: __	Do you have a history of trauma/loss from your family of origin? ○ Yes ○ No If yes, please describe below:
_	

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Mental Health History

Primary Client	Spouse/Partner
Have you ever been seen by another mental health provider before? ○ Yes ○ No If yes, Provide MH Provider Information, Approx Time Frame & Focus of Treatment	Have you ever been seen by another mental health provider before? ○ Yes ○ No If Yes, Provide MH Provider Information, Approx Time Frame & Focus of treatment:
Is/was the treatment helpful? ○ Yes ○ No If current, please list the name of your mental health provider:	Is/was the treatment helpful? ○ Yes ○ No If current, please list the name of your mental health provider:
Have you ever been hospitalized for mental health reasons? ○ Yes ○ No If yes, Provide MH Facility, Approx Time Frame & Reason for Hospitalization:	Have you ever been hospitalized for mental health reasons? ○ Yes ○ No If yes, Provide MH Facility Name, Approx Time Frame & Reason for Hospitalization:
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Counseling Needs

Please list the issues for which you are seeking couples counseling. Be as specific as possible. (These could be collective concerns as a couple, or separate concerns.)

What have you previously tried to address/resolve these issues? Has anything been helpful?

What do you consider to be your strengths as a couple?

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Counseling Goals

Goals are very important in counseling. They provide us with a focus and direction in working toward achieving therapy goals. Below you are goals as a couple that you would like to focus on during couples counseling. The next is how individually each of you can contribute to helping meet or improve upon your goals as a couple.

Primary Client	Spouse/Partner
Please list your top (3) goals that you would like to see changed/improved as a result of couples counseling?	Please list your top (3) goals that you would like to see changed/improved as a result of couples counseling?

Primary Client	Spouse/Partner
Please describe specific ways you are willing to contribute toward meeting those goals?	Please describe specific ways you are willing to contribute toward meeting those goals?

Thank you for completing this Couples intake form. Please sign & date below.

PRIMARY CLIENT SIGNATURE: _____ Date: _____

SPOUSE/PARTNER SIGNATURE: _____ Date: _____