CLIENT INTAKE FORM: COUPLES For therapy services with Jennifer A. Watts, Ph.D., LMFT
Date _____ 1762 Century BLVD NE, 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/gender identity/pronouns _____

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/gender identity/pronouns

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 ❑ widowed

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: