Laurie L. Rosen, *LCSW*
Licensed Clinical Social Worker

How were you referred?
_____

COUPLE INTAKE - To be completed by Spouse/Partner 1

(Email for scheduling & administrative purposes only)

Name_____DOB_____ EMAIL_____

Address City & Zip_____Identifying Gender_____

Preferred Phone for contact & messages CELL WORK HOME _____

Occupation, Employer & Address_____

ER Contact Name & Number (other than partner/spouse)_____

Duration of current marriage or relationship?_____

Previous Marriage(s)?_____ Dates & Duration_____

Children from current and previous marriages/relationships School/Grade/Where residing

Name_____DOB_____

Name_____DOB_____

Name_____DOB_____

Family & Medical History (Check all that apply indicating "S" for Self & "F" for Family

_____Depression _____Chronic Illness _____Neurological Problems _____Alcohol/Subst Abuse

_____Bipolar Diso _____Physical Disability _____Learning Disability _____ADHD/ADD

_____GI/Digestion _____ Mental Illness _____Personality Disorders _____Anxiety (OCD, panic)

_____Abuse: physical – sexual – emotional _____Physical Illness (ex: cancer) _____Other:_____

Current Medications & Who Prescribes?_____

Do you drink alcohol____ smoke_____ use drugs____ If yes, which & how often_____

Cutting Behavior_____Thoughts of Suicide_____ Suicide Attempts_____When_____

History of Medical/Mental Health Trauma_____

Previous Hospitalizations Where, When & Why_____

Name(s) of Previous Counselor(s)_____

Previous Counseling Issues_____

Are you adopted____ If so, at what age _____ Contact w/biological mother_____ biological father_____

Are your parents divorced _____ How old were you _____With whom did you reside_____

Mother's name, age, residence _____

Father's name, age, residence_____

Siblings names, ages, residences_____

Other significant family members in your life?_____

Significant family history/trauma: Relocation, Death, Divorce, Deployment, Conflictual Relationships

_____

_____

Religious affiliation as a child? _____ Religious affiliation as adult? _____
Highest level of education? _____ Financial/Legal problems? _____

Current Symptoms and Behaviors of Concern (Please check all that apply)

___ Anger
___ Addiction_____
___ Alcohol Use
___ Being Good to Yourself
___ Binge Drinking
___ Body Image
___ Career/ Work
___ Compulsions
___ Concentration Problems
___ Crying Excessively
___ Dating Concerns
___ Disorganization
___ Drug Use
___ Eating too much/little
___ Exercising too much/too little
___ Finances
___ Flashbacks
___ Hypervigilance
___ Impulsivity
___ Irritability
___ Lack of Ambition/Motivation
___ Marital/Couple Relationship
___ Nightmares
___ Obsessions
___ Overeating
___ Parent-Child Conflict
___ Passivity
___ Peer Relationships
___ Procrastination
___ Recklessness
___ Self-harming Behavior
___ Sexually Acting Out
___ Sexual Problems/Dysfunction
___ Sleeping Problems
___ Socializing
___ Social Withdrawal
___ Spiritual/Religious
___ Suicidality/attempts
___ Thoughts of Harming Self and/or Others
___Other_____

Physical Symptoms ("C" currently experiencing, and/or "P" in the past (all that apply)

___ Bowel Disturbance
___ Blackouts
___ Chronic Pain
___ Constant Hunger
___ Dizziness
___ Easily Startled
___ Excessive Fatigue/Tired
___ Excessive Sweating
___ Fainting
___ Headaches
___ Hearing Voices
___ Incoherent Thoughts
___ Numbness/Tingling
___ Poor appetite
___ Tension
___ Rapid Heartrate
___ Vision problems

Rate your current level of couple/marital satisfaction (circle a number)

EXTREMELY DISSATISFIED — EXTREMELY SATISFIED

1 2 3 4 5 4 6 7 8 9 10

What are your goal(s) for therapy?_____

_____

_____

How would you know things are improving?_____

_____

_____

Laurie L. Rosen, *LCSW*
Licensed Clinical Social Worker

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COUPLE INTAKE - To be completed by Spouse/Partner 2

(Email for scheduling & administrative purposes only)

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Occupation, Employer & Address_____

ER Contact Name & Number (other than partner/spouse)_____

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___ Exercising too much/too little
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