Clack Associates, LLC
Angela R. Clack, PsyD, LPC
License#37PC00323700

Couples Screening Form/Intake Assessment

Today's date: _____

Client Name: _____ DOB: _____ Age: _____

Who referred you to us: _____

Primary Address: _____ City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Highest level of education/Last grade completed:

_____

List additional training or certification obtained after high school or college:

_____

_____

Marital Status: Divorced ____ Engaged ____ Married ____ Never Married ____
Separated ____ Widowed ____

Spouse/partner name: _____ DOB: _____ Age: _____

If married, how many years? _____

Is this your first marriage? YES NO

If not, list the number of prior marriages that you have had: _____

If you are divorced or separated, please describe your past relationship with your spouse:

_____

If you are married, please describe your current relationship with your spouse:

_____

Client employment/primary source of income: _____

Other sources of income: _____

Current salary range: _____

Briefly describe your reason(s) for seeking help at this time: _____

_____

_____

_____

Have you ever been to counseling as a result of this problem(s) prior to today? YES NO

How long has this been a problem? _____

_____

_____

What other stressors are in your life that complicate the alleviation of distress?

_____

Couples Screening Form/Intake Assessment

_____

_____

_____

What have you already tried to cope with your current situation?

_____

_____

_____

_____

With everything that you are going through right now have you thought about doing anything drastic or perhaps violent to yourself or anyone else?

_____

_____

Have you ever had suicidal thoughts, feelings, or attempted suicide in the past?

_____

_____

Do you have any suicidal or homicidal thoughts now? _____

_____

Name of client's primary care physician: _____

Address: _____ Phone: _____

When was your last physical examination? _____

Are you on medication? (Include vitamins and over the counter drugs) Yes ____ No ____

Please list any medications you are currently prescribed or taking

Drug Name: _____ Dose: _____ Started: _____

Reason: _____

Drug Name: _____ Dose: _____ Started: _____

Reason: _____

Drug Name: _____ Dose: _____ Started: _____

Reason: _____

Drug Name: _____ Dose: _____ Started: _____

Reason: _____

Does client have any known allergies? Yes ____ No ____

If so, to what: _____

Is there any history of medical problems in client's family? Yes ____ No ____

Couples Screening Form/Intake Assessment

If yes, please describe: _____

_____

_____

List any major health problems for which you are currently receiving treatment:

_____

_____

_____

Have you or any member of your family received psychiatric and/or psychological help or counseling of any kind in the past? _____

_____

_____

If yes, who received treatment and the reason?

_____

_____

_____

Who provided these services and where?

_____

_____

_____

Was it helpful? Why or why not? _____

_____

Are you currently in treatment/counseling with a behavioral healthcare provider?

_____

_____

How will you know if treatment has been successful? _____

_____

_____

_____

_____

Do own or have access to any firearms, weapons, dangerous chemicals in your dwelling?

_____

_____

List any other important issues (i.e. legal suit, Workmen's Compensation, etc.): _____

_____

_____

Do you or your partner drink alcohol or use other drugs for intoxication? Yes ____ No ____

Couples Screening Form/Intake Assessment

If yes, have you or your partner received substance abuse treatment? Yes ____ No ____

If yes, with whom? _____

_____

Have either you or your partner struck, physically restrained, sue violent against or injured the other person? Yes ____ No ____

If yes, what happened?

_____

_____

_____

Has either of you threatened to divorce or separate as a result of the current marital problems?

Yes ____ No ____ If yes, who? _____

Do you perceive that either you or your partner has withdrawn from the relationship?

Yes ____ No ____ If yes, which of you has withdrawn? _____

How satisfied are you with your intimacy and sexual relations?

UNSATISFIED SATISFIED VERY SATISFIED

Legal status

Have you ever been arrested for any legal activities? Yes ____ No ____

If yes, please explain: _____

_____

When? _____

Are there any outstanding charges against you? Yes ____ No ____

If yes, please explain: _____

_____

Are you currently on probation? Yes ____ No ____

Activities and Social Group Participation

Please list all leisure, structured, and cultural activities in which you are currently participating:

_____

_____

_____

_____

Couples Screening Form/Intake Assessment

Please **circle** any of the following problems that pertain to your current situation:

- Nervousness
- Shyness
- Separation
- Drug use/alcohol
- Anger
- Sleep
- Legal matters
- Trauma
- Loneliness
- In laws
- Children
- Depression
- Sexual problems
- Self-control
- Stress
- Headaches
- Memory
- Insomnia
- Inferiority Feelings
- Career Choices
- Nightmares
- Appetite
- Being a Parent
- Health
- Marital/Relationship
- Digestion Problems
- Fears
- Suicidal Thoughts
- Finances
- Friends
- Unhappiness
- Work
- Fatigue
- Legal
- Making Decisions
- Concentration
- Eating Disorder
- Thoughts

- Other: _____

List all family members and others who are currently living in your home:

Name	Relationship	Age	Occupation

Third Party/Insurance Carrier

Insurance Carriers	Policy Holder	Group Number	Policy Number

Couples Screening Form/Intake Assessment

Portion of counseling services covered by insurance: _____
Deductible: _____ Co-Payment: _____
Insurance carrier's phone number for mental health/substance abuse benefits:_____
_____
_____

Couples Screening Form/Intake Assessment

*Please **initial** each of the following items to indicate your agreement:*

_____ Your insurance company/mental health care group might **require** that clinical information be provided to them in order for you to receive these services. If payment or pre-certification of benefits is denied by your carrier, you will be responsible for payment.

_____ All fees are payable at the time of visit(s), unless special arrangements have been made. Your insurance/mental health group might require pre-authorization for your treatment visits.

_____ Appointments cancelled without adequate notification (24 hour notice) or broken without justifiable reason will be billed at the missed session rate. This fee is not reimbursable by your policy coverage.

_____ _____

Date Your Full Signature