Intake Form For Couples Therapy

Lowey Psychological Services

Name of primary client : _____
(Last) (Given) (Preferred) (Middle Initial)

Birth date: _____/_____/_____ Age:_____ Gender: Male Female Transgender

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _____ Ages:_____

Current address: _____
(city) (state) (zip)

Best phone number:_____ May we leave a message? Yes No

Email address:_____ May we email you?* Yes No

**NOTE: Emails may not be confidential*

Occupation: _____ Employer: _____

Religious Affiliation (if any): _____

Who may we contact in case of an emergency: _____ Telephone number_____

Name of partner : _____
(Last) (Given) (Preferred) (Middle Initial)

Birth date: _____/_____/_____ Age:_____ Gender: Male Female Transgender

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _____ Ages:_____

Current address: _____
(city) (state) (zip)

Best phone number:_____ May we leave a message? Yes No

Email address:_____ May we email you?* Yes No

**NOTE: Emails may not be confidential*

Occupation: _____ Employer: _____

Religious Affiliation (if any): _____

Who may we contact in case of an emergency: _____ Telephone number_____

Referred by: Insurance company Internet search Word of mouth Advertisement Other:_____

Primary insurance co & identification number: _____
Insurance subscriber name and date of birth: _____

Secondary insurance identification number: _____
Insurance subscriber name and date of birth:_____

Is either member of the couple currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No
If yes, which member of the couple: _____
Current treatment provider: _____
Reason for being in therapy: _____

Is either member of the couple currently taking any psychiatric prescription medication? Yes No
If yes, which member of the couple: _____
Please list current medications: _____

Other Information

What is bringing you to couples therapy: _____
_____
_____

List your strengths and what you like most about your partnership:_____
_____
_____

List areas you feel you need to improve in your relationship: _____
_____
_____

What are your goals for therapy/what would you like to accomplish?

_____

_____

_____

By signing below, I am acknowledging that I have chosen to receive mental health services in the form of evaluation and psychotherapy from Dr. Robin Lowey & Associates Psychological Services. My decision is voluntary and I understand that I may terminate these services at any time. I also understand that during the course of treatment I may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that I will feel better after completion of treatment.

_____ _____

Signature Date