Tending Relationships P.L.L.C.
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Email: Kellee@tendingrelationships.com
Website : www.tendingrelationships.com

Intake Questionnaire and Registration Form for Couples Therapy

The intake questionnaire is intended to help me understand your relationships and the broader context of your life from each partner's perspective so that I can support you more effectively. Please have each partner fill out and mail the questionnaire to the address shown above at least 4 business days prior to your first appointment.

Contact Info

Name:		Date of Birth	
Address:			
Primary Phone		Initial if Voice & Text Message are OK?	Voice: Text:
Secondary Phone			Voice: Text:
Email		Initial if Email is OK?	
Emerg. Contact Name/ Relationship		Phone #	

Personal Info

Culture/Race		Religion	
Gender		Sexual Preference:	
Marital Status		Spouse/Partner's Name	

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Education (degrees and/or what you are currently studying):

Employment (significant past and/or current work if applicable):

History of the Current Problem

Please provide a brief description of your reasons for seeking counseling at this time.

How have these concerns evolved over time?

What are your goals for our counseling work?

Relationship Information:

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Please circle your current level of commitment, confidence and distress in your relationship:

Level of commitment	Level of confidence	Level of distress
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Low High	Low High	Extremely Extremely Happy Unhappy

Describe the frequency and intensity of conflict in your relationship:

List the top 3 recurring themes that continue to surface in conflict with each other:

If conflict has ever become physical within your relationship, describe the situation:

Describe your level of satisfaction with your sexual relationship:

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Health Related Information:

Name of Personal Physician: _____
(We would only contact your doctor with your permission.)
Phone Number: _____

Are you currently under medical care? Y / N
If yes, then please explain/describe:

Are you currently taking prescribed medications? Y / N
If yes, then please explain/describe (e.g. current dosage, length of time taken):

List any psychiatric/mental health medications you have taken including dosage and period of time taken (Other than listed above):

List any supplements or vitamins that you have taken in support of mental health and the circumstances of your use:

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If you were ever under the care of a psychiatrist, psychologist, or counselor, provide the caregiver's name, when the therapy took place, and the nature of the problem:

Have you ever been hospitalized for a mental health condition? Y / N
If yes, please give the date and briefly explain the nature of the problem:

Have you ever been in a drug or alcohol treatment program? Y / N
If yes, please give the facility, length of time in treatment and outcome:

Lifestyle Information:

Please check any of the following struggles that pertain to you:

☐ Anxiety	☐ Depression	☐ Fears/Phobias	☐ Eating Disorders
☐ Sexual Problems	☐ Suicidal Thoughts	☐ Separation/Divorce	☐ Relationships
☐ Finances	☐ Drug/Alcohol Use	☐ Career Choices	☐ Anger
☐ Self-Control	☐ Unhappiness	☐ Insomnia	☐ Religious Matters
☐ Work/Stress	☐ Health Problems	☐ Cutting/ Self-Mutilation	☐ Disturbing/ Repetitive Thought Patterns

How much sleep are you getting each night on average? _____ hours

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Do you have any concerns regarding sleep or rest? Y / N

Do you currently drink alcohol? Y / N
How much? How often?

Do you currently use recreational drugs? Y / N
How much? How often? What substances?

Do you think you have a problem with either alcohol or drugs? Y / N

Have you ever attempted or considered suicide? Y / N
If yes, please provide some details:

Have you ever considered harming anyone else, or actually done so? Y/N
If yes, please provide some details:

Describe any recent weight gain or loss and the circumstances that surround it:

Is there anything else you think would be helpful to know about prior to our first session?

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This information is, to the best of my knowledge, true and I understand that it may be used in my treatment.

Signed and Attested _____ This Date: _____

Name: _____ Date of Birth: _____