

Dr. Vivian Sierra, LLC

Initial Intake Questionnaire – Couples Therapy |

The following questionnaire is designed to gather initial intake information that is needed to open your case and to gather initial assessment information regarding your treatment needs. Please complete this form to the best of your ability. If you have any questions regarding the contents of this questionnaire or are not comfortable answering a particular question, please leave the item blank or ask for assistance. Thank you!

Referral Source: _____

Today's Date: _____

Client Name: _____

Date of Birth: _____

Spouse/Partner Name: _____

Date of Birth: _____

Address of Primary Residence:

Spouse/Partner's Address (if different) :

Home Phone:

Please check if OK to leave a message at this number ____

Cell Phone:

Please check if OK to leave a message/text at this number ____

Please list names and ages of other family members currently living in the home:

General Relationship History:

How long have you and your spouse/partner been together? _____

If married, how many years? How long did you date prior to marriage? _____

How did you meet your spouse/partner? _____

How would you describe your relationship? _____

How would your spouse/partner describe your relationship? _____

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Education and Employment Highest Education Received:

Occupation:

Highest Education Level: _____

Occupation _____ Name of Employer: _____

Are you experiencing any current difficulties with occupational performance? If yes, please explain:

Spouse's/Partner's Highest Education Received: _____

Spouse's/Partner's Occupation: _____ Name of Employer: _____

Is your spouse/partner experiencing any current difficulties with occupational performance? If yes, please explain:

Family Mental Health Background *

Please answer the following questions as related to both yourself and your spouse/partner's family background.

Have you or anyone in your family received mental health services before?

If yes: Who received services?

Who provided these services? For how long did you and/or your family members participate in mental health services?

What issue(s) was the focus of treatment at that time?

How would you describe the experience you and/or your family members have had with mental health services? (i.e., positive, helpful, not helpful)

Is a psychiatrist currently treating you or any of your family members? If yes, please identify the person who is currently being treated, the reason for treatment, the psychiatrist name and the type (name is known) of medication:

Have you or anyone in your family ever been hospitalized for mental health reasons? If yes, please identify who in your family has been hospitalized, the date(s), reason(s) and location(s):

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Family Medical Background:

Have you or anyone in your family ever been diagnosed with a serious medical condition? Please describe:

Are you or anyone in your family currently experiencing any medical/physical symptoms that are related to a mental, emotional, or stress-related condition? Please describe:

Current or Past Family Stressors

Is there a history of mental illness in your family? Please describe:

Is there a history of addiction in your family? Please describe:

Is there a history of abuse or violence in your family? Please describe:

Additional Information

Is there any additional information that you feel is important to provide at this time?