Arkansas Relationship Counseling Center

Intake Evaluation Form

Date: _____

Name:_____ DOB: _____ Age: _____ Race: _____
Spouse/Partner Name: _____DOB:_____ Age: _____ Race: _____

Address: _____City: _____ State:_____ Zip:_____
Is this a good address to send documents? ❑ Yes ❑ No

Cell Phone: _____ Home Phone: _____ Email: _____
Spouse/Partner Cell Phone: _____ Home Phone: _____ Email: _____

Educational Status (Highest level completed): _____
Spouse/Partner Educational Status: _____

Occupation: _____ Place of Business: _____
Work Address: _____ Zip: _____ Work Phone: _____

Spouse/Partner Occupation: _____ Place of Business: _____
Work Address: _____ Zip: _____ Work Phone: _____

Family History

Is there any other person living in your household? ❑ YES ❑ NO
If yes, please give their name(s), age(s), and their relationship to you?

_____
_____

Have you ever been married? ❑ YES ❑ NO
If yes, to whom and for how long?

_____
_____

Spouse/partner ever been married? ❑ YES ❑ NO
If yes, to whom and for how long?

_____
_____

Do you have any children? ❑ YES ❑ NO If yes, please list below.

_____
_____

Spouse/Partner has any children? ❑ YES ❑ NO If yes, please list below.

_____
_____

COUNSELING HISTORY

From: _____To: _____ With Whom? _____
For What? _____

SPOUSE/PARTNER COUNSELING HISTORY
From: _____To: _____ With Whom? _____
For What? _____

BASIC PHYSICAL HEALTH: ❑ Good ❑ Fair ❑ Poor When was your last physical exam? _____
SPOUSE/PARTNER PHYSICAL HEALTH: ❑ Good ❑ Fair ❑ Poor Last physical exam? _____

Are you or Spouse/Partner taking any medication at this time? ❑ YES ❑ NO
If yes, what?

_____

Are you or Spouse/Partner taking any over the counter medications, herbs, supplements, etc.? ❑ YES ❑ NO
If yes, what?

_____

Are you or Spouse/Partner taking any medications for allergies? ❑ YES ❑ NO
If yes, what?

_____

Have you or Spouse/Partner ever, or are you now being treated for any type of chemical abuse? ❑ YES ❑ NO
If yes, what and treated by whom?

_____

Are you or Spouse/Partner at the present time using any type of chemical substance? ❑ YES ❑ NO
If yes, please indicate what you are using (drugs and/or alcohol)

_____
How frequently do you or Spouse/Partner use these substances?

_____

Do you or Spouse/Partner have any physical, emotional, or mental condition now or in the past that I need to be aware of? ❑ YES ❑ NO If yes, what?

_____
_____

Have you or Spouse/Partner ever been hospitalized? ❑ YES ❑ NO If yes, for what?

_____
_____

CURRENT REASON FOR SEEKING COUNSELING:

Briefly describe the problem for which you are seeking counseling?

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

The thing which concerns me the most right now is?

_____

_____

CURRENT REASON FOR <u>PARTNER</u> SEEKING COUNSELING:

Briefly describe the problem for which you are seeking counseling?

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

The thing which concerns me the most right now is?

_____

_____

Person to contact in case of an emergency: _____ Phone: _____

Please select primary reason for choosing this agency.

- Referred by: _____ Address: _____ Phone: _____
  May we contact the above source and thank them for the referral? q YES q NO
- Seen on TV
- Convenience of location
- Online search
- Price
- Other _____

Signature: _____ Date: _____

Spouse/Partner Signature:_____Date:_____