STICKS & STONES
THERAPEUTIC SERVICES

Couples Counselling

Client Intake Form

Intake Date:

Please take your time when answering the questions that follow. Feel free to attach additional pages or complete the form individually if necessary. NOTE: The information you provide here is protected as confidential information.

Personal Information

Person 1

First Name | Last Name

Preferred Name | Gender

Date of Birth | Phone

Email

Address

Please select which contact details we can leave a message

☐ Phone ☐ Email ☐ Both ☐ None

Please tick ALL that apply to you

☐ Aboriginal/Torres Strait Islander
☐ From isolated/rural area
☐ Person with a disability
☐ Non-english speaking background
☐ LGBTQI+

- these are Equity Charters which help with the evaluation of our service delivery

Emergency Contact

First Name | Last Name

Phone | Relationship

- *Please note: By providing this information you are giving consent to Sticks n' Stones Therapeutic Services to make contact with this person in the event of no contact with you and/or in an emergency*

Person 2

First Name | Last Name

Preferred Name | Gender

Date of Birth | Phone

Email

Address

Please select which contact details we can leave a message

☐ Phone ☐ Email ☐ Both ☐ None

Please tick ALL that apply to you

☐ Aboriginal/Torres Strait Islander

☐ From isolated/rural area

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Emergency Contact

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Who is the primary contact for this application?

☐ Person 1

☐ Person 2

☐ Both

☐ Please contact us seperatly

Are both of you willing to engage in this service?

☐ Yes

☐ Person 2 is & Person 1 is not

☐ Person 1 is & Person 2 is not

☐ We are both unsure

Relationship Information

Is anyone concerned about your safety as a couple?

☐ Yes ☒ No ☐ Unsure

Please list any children (Names, Age, Gender, Relationship with Person 1 & Person 2)

How long have you and your partner been together? In what form? (i.e., dating, living together, married, children)

What is the problem that led you to decide to come to therapy?

What significant stressful events have you experienced in your relationship recently?

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? If yes for either, who, how often and what substances are used?

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? If yes for either, who, how often and what substances are used?

Has anyone in the family ever struck, physically restrained, used violence against or injured any other person within the family? (If yes, please explain)

Have either of you considered separating or divorce as a result of the current relationship problems? If so, when?

List some strengths in your relationship

Person 1

Person 2

List some weaknesses in your relationship

Person 1

Person 2

What would you like to accomplish out of your time in couples therapy? (i.e. what would be different in your relationship)

Person 1

Person 2

What have you already done to deal with the difficulties and how successful was it? (e.g. previous counselling for 2 months last year, not that successful)

Have either you or your partner been in individual counselling before? If so, give a brief summary of concerns that you addressed.

Please provide any other information that you believe is important (e.g. overall stress levels, work issues, housing issues, other family problems, intimacy issues, mental health difficulties etc)

Person 1

Person 2