



Client Intake Form

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
- Non-english speaking background
- From isolated/rural area
- LGBTQI+
- Person with a disability

• 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 Non-english speaking background
 From isolated/rural area LGBTQI+
 Person with a disability

- 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

Who is the primary contact for this application?

- Person 1 Both
 Person 2 Please contact us separately

Are both of you willing to engage in this service?

- Yes Person 1 is & Person 2 is not
 Person 2 is & Person 1 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?

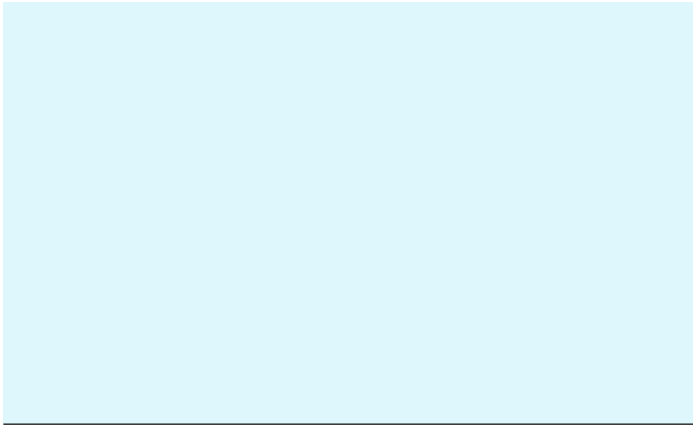
List some strengths in your relationship

Person 1

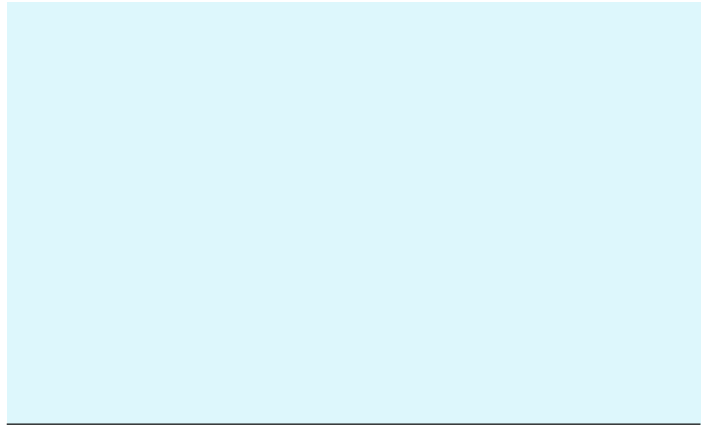
Person 2

List some weaknesses in your relationship

Person 1

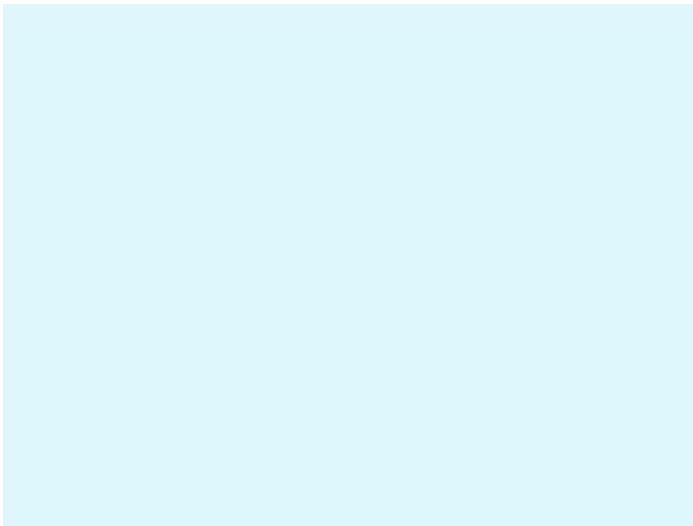


Person 2

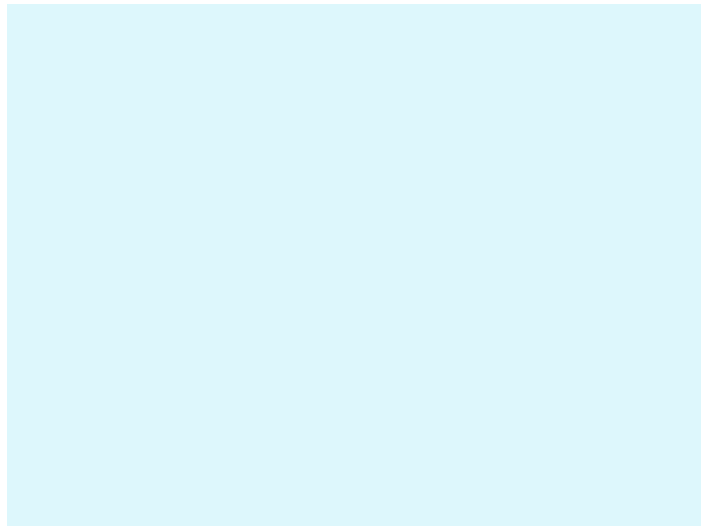


What would you like to accomplish out of your time in couples therapy?
(i.e. what would be different in your relationship)

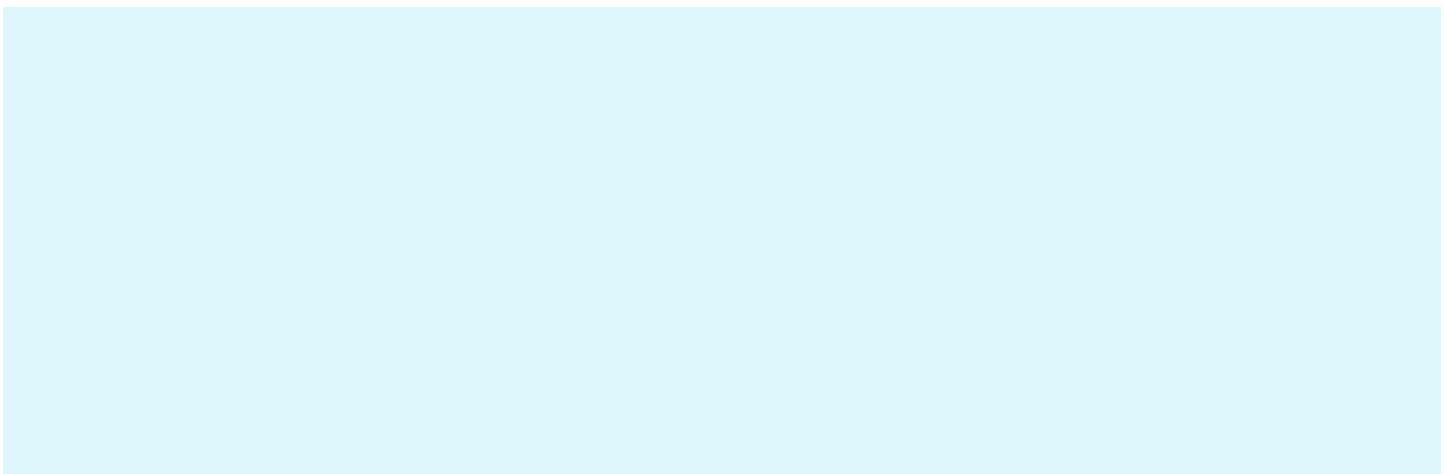
Person 1



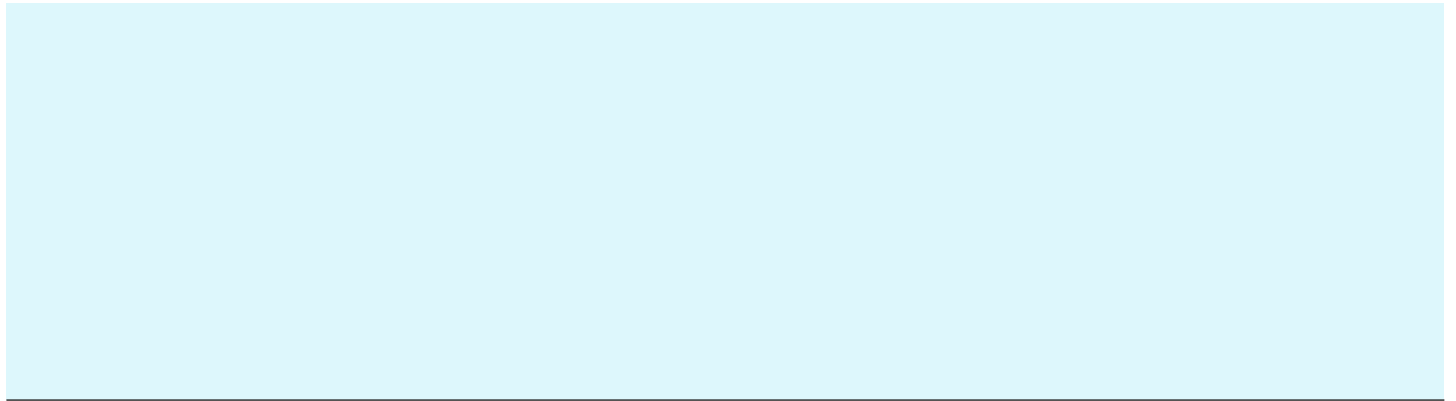
Person 2



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)

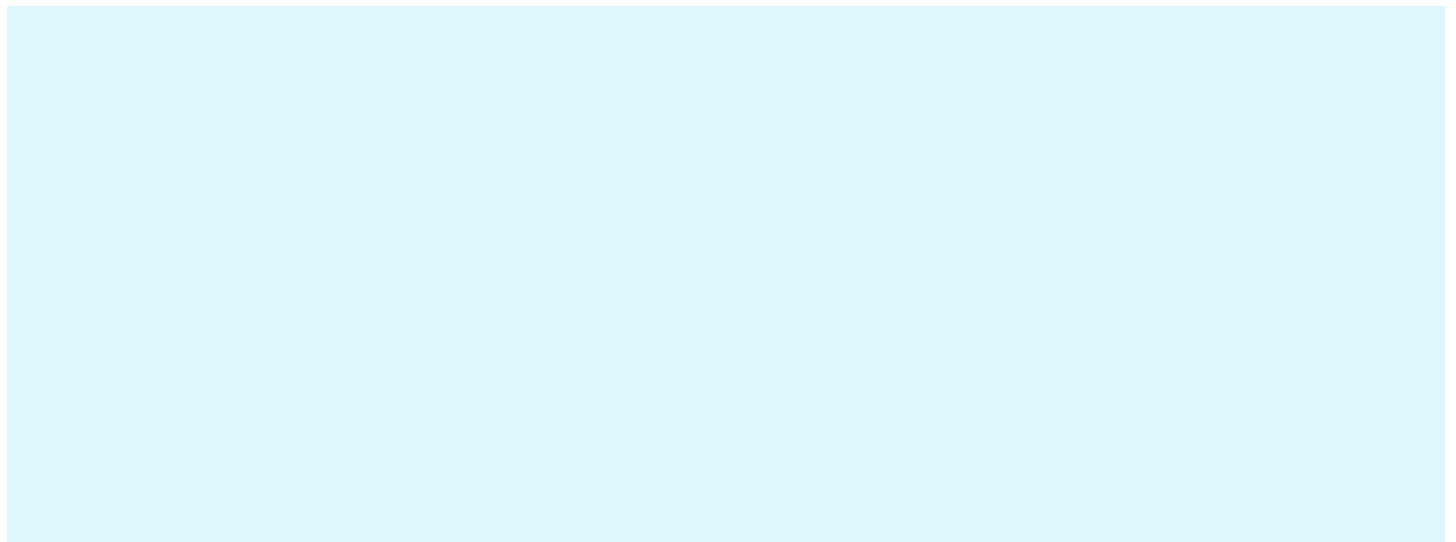


Have either you or your partner been in individual counselling before? If so, give a brief summary of concerns that you addressed.



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

