

Rhonna W. Phillips
Counseling & Therapy Services, LLC

TO BEGIN THE PROCESS AND PREPARE FOR YOUR INITIAL COUPLES' INTAKE APPOINTMENT PLEASE, EACH OF YOU, COMPLETE THE PSYCHOSOCIAL HISTORY FOR INDIVIDUAL INTAKE ASSESSMENT FORMS.

Two sets are attached below and can be printed out. Each set is 5 pages per person. You can scan them and email them to me in advance or bring them with you when you come. If you don't you will need to complete yours during your appointment time and this will limit our discussion time.

This information will provide me a basis to begin to understand each of your upbringings, backgrounds and the foundations for your personal values, which you may have brought to your relationship. It will also help us use our time efficiently and conveniently.

During our appointment time I will personally ask you the Couple's Assessment questions. These will pertain to the nature of your concerns, your communication, problem solving and/or dispute resolution styles.

Please call me if you have any questions about this process. I look forward to working with you!

Rhonna W. Phillips, MA

Licensed Professional Counselor- Supervisor
Licensed Marriage and Family Therapist
Collaborative Practitioner
Qualified Family & Domestic Relations Mediator

Rev 05-2016

Rhonna W. Phillips

Counseling & Therapy Services, LLC

PSYCHOSOCIAL HISTORY FOR INDIVIDUAL INTAKE ASSESSMENT

Client Name: _____ Intake date: _____

Preferred or nickname: _____ DOB: _____ Age: _____

Address: _____ City _____ State: _____ Zip _____

Cell Phone: _____ Home Phone: _____ IDs Gender as: _____

Ethnicity as: _____ Country born in: _____

Highest Grade/degree completed: _____ Major: _____ Military service? You or close relative? _____

Current School: _____ for _____

Completed grade: _____ Current Job: _____

Co: _____ How long? _____

Currently living with? _____ Referred by: _____

Problem? “ _____ ”

Event that triggered appt: _____

Attach separate notes if you prefer to write more detail.

SOCIAL & Current Intimate relationship:

Circle current intimate relationship status:

Dating, Girl/Boyfriend, Live together, Marriage # _____

Year/Age Met _____ where _____ Year/Age began Dating _____

Year/Age Lived together _____ Year/Age Married _____ partner was

age _____ # yrs married _____ Who else resides w/you? _____

Names/Gender/Age of kids biological to you both:

Partners' kids: _____

Rhonna W. Phillips
Counseling & Therapy Services, LLC

Sig rel/ Marriage # _____ Year/Age met _____ Year/Age dated _____
Year /Age lived together _____ Year/Age married _____ # yrs married _____
Year/ Age divorced _____ Why _____

Children's Names/Gender/Age: _____
_____ Stepchildren from this relationship- Names/Gender/Age: _____

Which of these children visit w/you now? _____

Sig rel/ Marriage # _____ Year/Age met _____ Year/Age dated _____
Year /Age lived together _____ Year/Age married _____ Year/ Age
divorced _____ Why _____ Children's Names/Gender/Age: _____

_____ Stepchildren from this relationship- Names/Gender/Age: _____

Which of these children visit w/you now? _____

Other Significant Intimate Relationships past or present _____

Age 1st sexually active _____ Sexual identity _____ # sex partners in past 6
mos _____ Intimate relationships' happiest memory _____

Intimate relationship's worst memory _____

Any: Domestic Violence Y/N _____ **Legal Probs** Y/N _____

DUI Y/N _____ **Arrests** Y/N _____ **Court Dates** _____

Name of Lawyer _____ **Court orders** _____

Name of Probation officer _____ **Lawsuits** Y/N _____

Child Support paid & current or unpaid _____ **\$ Concerns** Y/N _____

Attach additional notes if needed to explain.

Rhonna W. Phillips

Counseling & Therapy Services, LLC

FAMILY OF ORIGIN:

Support system is: _____ **Religion:** Raised _____,
Current Religion: _____ Attend: _____

Parents Married _____ yrs, If Divorced you were age _____ You lived w/ _____
Mother remarried Y/N # _____ Father Remarried Y/N # _____ Contact w/ non
custodial parent was: _____ Relationship
w/ Step Fa was: _____ w/ Step Mo was: _____

Bio **Siblings:** Name/Gender/Age: _____

½ sibs or Step sibs Name/Gender/Age _____

Happiest memory of childhood _____

Worst memory of childhood _____

History of Abuse: Verbal Y/N Emotional Y/N Physical Y/N Sexual Y/N Explain: _____

MENTAL/ HEALTH TREATMENT:

Any past or present **Medical** Conditions: _____

chronic conditions _____ Hosp: _____ Surgeries: _____

Allergic to any RX? _____

Tobacco use per day _____ **Alcohol use:** Beer # per day/week _____

Wine # per day/week _____ Hard Liquor # per day/week _____

Substances that you use socially/ recreationally: _____

Freq per week _____ Substances you abuse: _____

_____ Freq per week _____ Have you or anyone close to

you ever been concerned about your Alcohol or substance use? _____

Rhonna W. Phillips

Counseling & Therapy Services, LLC

Past **Psychiatric** treatment Y/N: Dr. _____ for _____ Yr _____

Dr. _____ for _____ Yr _____

If any Residential treatment or Psychiatric hospitalizations please list, by date, on separate paper

Current/recent **Mental health Counseling** providers: Where _____

w/ who _____ Since _____ for _____

Counselor _____ Year _____ for _____.

Counselor _____ Year _____ for _____.

Counselor _____ Year _____ for _____.

If considering a change why? _____

Past Medication: _____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

Current Medication, Herbs & Supplements, incl contraception:

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

Add separate page if additional space is needed

Family Mental Health History:

(Depression, Anxiety, Substance Abuse, Hospitalizations, Suicide Attempts, etc)

Mother: _____ **Maternal Grandparents:** _____

Aunts/Uncles: _____ **Cousins:** _____

Father: _____ **Paternal Grandparents:** _____

Aunts/Uncles: _____ **Cousins:** _____

Siblings: _____ **Kids:** _____

Rhonna W. Phillips

Counseling & Therapy Services, LLC

PSYCHOSOCIAL HISTORY FOR INDIVIDUAL INTAKE ASSESSMENT

Client Name: _____ Intake date: _____

Preferred or nickname: _____ DOB: _____ Age: _____

Address: _____ City _____ State: _____ Zip _____

Cell Phone: _____ Home Phone: _____ IDs Gender as: _____

Ethnicity as: _____ Country born in: _____

Highest Grade/degree completed: _____ Major: _____ Military service? You or close relative? _____

Current School: _____ for _____

Completed grade: _____ Current Job: _____

Co: _____ How long? _____

Currently living with? _____ Referred by: _____

Problem? “ _____ ”

Event that triggered appt: _____

Attach separate notes if you prefer to write more detail.

SOCIAL & Current Intimate relationship:

Circle current intimate relationship status:

Dating, Girl/Boyfriend, Live together, Marriage # _____

Year/Age Met _____ where _____ Year/Age began Dating _____

Year/Age Lived together _____ Year/Age Married _____ partner was

age _____ # yrs married _____ Who else resides w/you? _____

Names/Gender/Age of kids biological to you both:

Partners' kids: _____

Rhonna W. Phillips
Counseling & Therapy Services, LLC

Sig rel/ Marriage # _____ Year/Age met _____ Year/Age dated _____
Year /Age lived together _____ Year/Age married _____ # yrs married _____
Year/ Age divorced _____ Why _____

Children's Names/Gender/Age: _____
_____ Stepchildren from this relationship- Names/Gender/Age:

Which of these children visit w/you now? _____

Sig rel/ Marriage # _____ Year/Age met _____ Year/Age dated _____
Year /Age lived together _____ Year/Age married _____ Year/ Age
divorced _____ Why _____ Children's Names/Gender/Age:

_____ Stepchildren from this relationship- Names/Gender/Age:

Which of these children visit w/you now? _____

Other Significant Intimate Relationships past or present _____

Age 1st sexually active _____ Sexual identity _____ # sex partners in past 6
mos _____ Intimate relationships' happiest memory _____

Intimate relationship's worst memory _____

Any: Domestic Violence Y/N _____ **Legal Probs** Y/N _____

DUI Y/N _____ **Arrests** Y/N _____ **Court Dates** _____

Name of Lawyer _____ **Court orders** _____

Name of Probation officer _____ **Lawsuits** Y/N _____

Child Support paid & current or unpaid _____ **\$ Concerns** Y/N _____

Attach additional notes if needed to explain.

Rhonna W. Phillips

Counseling & Therapy Services, LLC

FAMILY OF ORIGIN:

Support system is: _____ **Religion:** Raised _____,
Current Religion: _____ Attend: _____

Parents Married _____ yrs, If Divorced you were age _____ You lived w/ _____
Mother remarried Y/N # _____ Father Remarried Y/N # _____ Contact w/ non
custodial parent was: _____ Relationship
w/ Step Fa was: _____ w/ Step Mo was: _____

Bio **Siblings:** Name/Gender/Age: _____

½ sibs or Step sibs Name/Gender/Age _____

Happiest memory of childhood _____

Worst memory of childhood _____

History of Abuse: Verbal Y/N Emotional Y/N Physical Y/N Sexual Y/N Explain: _____

MENTAL/ HEALTH TREATMENT:

Any past or present **Medical** Conditions: _____

chronic conditions _____ Hosp: _____ Surgeries: _____

Allergic to any RX? _____

Tobacco use per day _____ **Alcohol use:** Beer # per day/week _____

Wine # per day/week _____ Hard Liquor # per day/week _____

Substances that you use socially/ recreationally: _____

Freq per week _____ Substances you abuse: _____

_____ Freq per week _____ Have you or anyone close to

you ever been concerned about your Alcohol or substance use? _____

Rhonna W. Phillips

Counseling & Therapy Services, LLC

Past **Psychiatric** treatment Y/N: Dr. _____ for _____ Yr _____

Dr. _____ for _____ Yr _____

If any Residential treatment or Psychiatric hospitalizations please list, by date, on separate paper

Current/recent **Mental health Counseling** providers: Where _____

w/ who _____ Since _____ for _____

Counselor _____ Year _____ for _____.

Counselor _____ Year _____ for _____.

Counselor _____ Year _____ for _____.

If considering a change why? _____

Past Medication: _____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

Current Medication, Herbs & Supplements, incl contraception:

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

Add separate page if additional space is needed

Family Mental Health History:

(Depression, Anxiety, Substance Abuse, Hospitalizations, Suicide Attempts, etc)

Mother: _____ **Maternal Grandparents:** _____

Aunts/Uncles: _____ **Cousins:** _____

Father: _____ **Paternal Grandparents:** _____

Aunts/Uncles: _____ **Cousins:** _____

Siblings: _____ **Kids:** _____

Rhonna W. Phillips
Counseling & Therapy Services, LLC

Any other important information to share: _____

OFFICE NOTES: Potential Tx Goals: _____

Plan _____

HMWK _____ RTC _____

Rhonna W. Phillips, MA

Date

Licensed Professional Counselor- Supervisor
Licensed Marriage and Family Therapist
Collaborative Practitioner
Qualified Family & Domestic Relations Mediator

Rev 05-2016