



**Center of Solutions**

P.O. Box 764  
Holland, OH 443528

**Phone:** 888-606-1962

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## Couples Therapy/Coaching Intake Form

Your answers to the following questions will be helpful in developing a therapy/coaching plan for you. Please answer each item carefully. The information you provide here is confidential, per the standards outlined in the Terms of Service.

This form must be completed, signed & returned to Center of Solutions, LLC before you are able to begin therapy or coaching.

Today's Date: \_\_\_\_\_

Personal Information:

Full Name: \_\_\_\_\_

Nickname/Name you want to be called: \_\_\_\_\_

Age: \_\_\_\_\_

Birth Date: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Does anyone else have access to your e-mail address? Yes No

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell/Alternate Phone: \_\_\_\_\_

May we say who we are if we phone your home? (circle one) Yes No

May we say who we are if we phone your work? (circle one) Yes No

May we say who we are if we phone your Cell/alt number? (circle one) Yes No

### Primary Goals of Therapy or Coaching

What is the problem that motivated you to make this appointment?

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Have you received counseling for these particular issues before? If yes, please explain.

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How long has this problem been going on?

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What have you done about the issues/problems?

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What steps have you taken to improve your situation?

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What specific things do you want to see changed in your life/relationship?

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What are you expecting to receive from counseling?

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Any other additional comments or information you think the therapist or coach should know about you or your situation?

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**Circle Any of the Following That May Apply to You:**

Headaches  
Dizziness  
Fainting Spells  
No Appetite  
Over-Eating Obsessions  
Stomach Trouble  
Suicidal Ideas  
Always Tired  
Always Sleepy  
Unable To Relax  
Insomnia  
Recurrent Dreams  
Nightmares  
Hallucinations

Inferiority Feelings  
Feel Tense  
Feel Panic  
Fears and Phobias  
  
Depressed  
  
Can't Make Decisions  
Alcoholism  
Dangerous Drugs  
Gambling Addiction  
Job Problems  
Homosexuality  
Sexual Problems

Shy With People  
Can't Make Friends  
Afraid Of People  
  
Unable To Have A Good Time  
Always Worried About Something  
Don't Like Weekends/Vacations  
  
Over-Ambitious  
Financial Problems  
  
Can't Keep A Job

**Please explain any of the circled items:**

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**Alcohol and Drug Use:**

**Do you use alcohol? How Much? How Often?**

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**Prescription Medications:**

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**Illegal Drugs What drug? How much? How often?:**

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**Relationship Information**

**Relationship Status:**

- Single
- Married
- Separated
- Divorced
- Committed relationship

**Living Arrangement:**

- Alone
- With Spouse
- With Roommate
- With Boyfriend/Girlfriend/Partner
- With Other Family

Have you ever been separated? Yes/No If yes, how many times? \_\_\_\_\_

Are you separated now? Yes/No

How long have you been married? \_\_\_\_\_ Previous marriages? Yes/No How many? \_\_\_\_\_

How long did you know your spouse before marriage? \_\_\_\_\_ Dated how long? \_\_\_\_\_

**Close friend/relative we may contact in case of a true emergency :**

**Relationship to you:** \_\_\_\_\_

**Phone Address:** \_\_\_\_\_

**City State Zip:** \_\_\_\_\_

**Occupational/Educational Information:**

**What is your occupation?** \_\_\_\_\_

**Do you enjoy your job?** (circle one) Yes No

**Please indicate which day and time would be best for you for your therapy/coaching sessions.  
Be sure to include your time zone.**

**Day** \_\_\_\_\_

**Time** \_\_\_\_\_

**Time Zone** \_\_\_\_\_

**All above information is accurate to the best of my knowledge.**

\_\_\_\_\_  
**Client name Print and Date**

\_\_\_\_\_  
**Signature**