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**COUPLES – Confidential Intake Questionnaire**

*These questions are intended to help me understand what you hope to gain from counseling, and some general information about you and your marriage/relationship. You are not obligated to share your answers with your partner, nor answer every question. Please skip any item that makes you uncomfortable.*

Name:       Today’s Date:       Birth date:

Address:

Age:       Sex at birth:       Preferred gender:

Phone #:       Email:       Preferred means of contact:

Employer/School/Work situation:

Emergency Contact name:       Emergency contact #:

Partner’s name:       Partner’s age:

Partner’s sex at birth:       Partner’s preferred gender:

**About your appointment:**

How did you learn about me/my practice?

If applicable, is it okay for me to thank whomever referred you to me? Yes [ ] ; No [ ]

Please provide a brief statement explaining your greatest concerns about the relationship:

What do you believe are your partner’s greatest concerns about the relationship?

**Current treatment:**

If you have been diagnosed with a mental health condition, please identify what it is and whether you are in treatment at this time:

Are you are seeing an individual therapist? Yes [ ] ; No [ ]

If yes, who are you seeing, and is it okay for me to contact your individual therapist regarding our sessions?

**About your marriage/relationship:**

What are the strengths of your relationship – what do (or did) you enjoy about your marriage?

How do you and your partner resolve conflict or differences in opinion?

Please describe any significant events that have impacted your relationship (e.g., an affair, infertility, abuse, etc.).

In what way do you hope your marriage will change as a result of coming to therapy?

**Please identify those areas which are a concern for you (otherwise leave blank):**

|  |  |  |  |
| --- | --- | --- | --- |
| Overall communicationMoney/financesInfidelityTrustFinding shared activitiesExtended family conflictParenting practicesWork/life balanceDomestic choresReligious practices | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | Our sex lifeOverall intimacyDrug/alcohol abuseThreat of divorce/separationCurrent verbal abuseCurrent physical abuseHistory of abuseChronically ill childLife valuesLife goals | **[ ]** **[ ]** **[ ]** **[ ]** **[ ]** **[ ]** **[ ]** **[ ]** **[ ]** **[ ]**  |

**General health questions (Optional):**

Overall, how do you feel about yourself and the life you are leading?

Please take a moment to let me know more about you as a whole person, such as your interests, accomplishments, skills, future ambitions, and enjoyed activities:

|  |
| --- |
| Patient Health Questionnaire PHQ-9Over the last two weeks how often have you been bothered by any of the following problems?  |
|  | Not at all | Several days | More than half the days | Nearly every day |
| Little interest or pleasure in doing things  | [ ]  | [ ]  | [ ]  | [ ]  |
| Feeling down, depressed, or hopeless  | [ ]  | [ ]  | [ ]  | [ ]  |
| Trouble falling/staying asleep, sleeping too much  | [ ]  | [ ]  | [ ]  | [ ]  |
| Feeling tired or having little energy  | [ ]  | [ ]  | [ ]  | [ ]  |
| Poor appetite or overeating | [ ]  | [ ]  | [ ]  | [ ]  |
| Feeling bad about yourself, or that you are a failure, or have let yourself or your family down | [ ]  | [ ]  | [ ]  | [ ]  |
| Trouble concentrating on things, such as reading the newspaper or watching TV | [ ]  | [ ]  | [ ]  | [ ]  |
| Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual  | [ ]  | [ ]  | [ ]  | [ ]  |
| Thoughts that you would be better off dead or of hurting yourself in some way  | [ ]  | [ ]  | [ ]  | [ ]  |

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| Anxiety GAD-7Over the last two weeks how often have you been bothered by any of the following problems? |
|  | Not at all | Several days | More than half the days | Nearly every day |
| Feeling nervous, anxious or on edge  | [ ]  | [ ]  | [ ]  | [ ]  |
| Not being able to stop or control worrying  | [ ]  | [ ]  | [ ]  | [ ]  |
| Worrying too much about different things  | [ ]  | [ ]  | [ ]  | [ ]  |
| Trouble relaxing  | [ ]  | [ ]  | [ ]  | [ ]  |
| Being so restless that is hard to sit still | [ ]  | [ ]  | [ ]  | [ ]  |
| Becoming easily annoyed or irritable  | [ ]  | [ ]  | [ ]  | [ ]  |
| Feeling afraid as if something awful might happen  | [ ]  | [ ]  | [ ]  | [ ]  |

If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

[ ]  Not difficult at all; [ ] Somewhat difficult; [ ] Very difficult; [ ] Extremely difficult

*Thank you for taking the time to answer these questions. I look forward to discussing your responses when we meet.*