RENÉE DIVINE LMFT
Relationship & Sex Therapist

CLIENT INTAKE FORM

Thank you for completing this. It helps me to better assist you during therapy. The information you provide here is protected as confidential information.

Full Legal Name: _____ Date: _____

Preferred Name: _____

Address: _____

_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: ◻ Male ◻ Female

Name of parent/guardian (if under 18 years): _____

Home Phone: _____ May I leave a message? ◻ Yes ◻ No

Cell/Other Phone: _____ May I leave a message? ◻ Yes ◻ No

E-mail: _____ May I email you? ◻ Yes ◻ No

Would you like to receive appointment reminders? ◻ Yes, ◻ Email or ◻ Text ◻ No

Relationship Status: ◻ Never Married ◻ Partnership ◻ Married ◻ Separated ◻ Divorced ◻ Widowed

How did you find me?
◻ Referred by someone (name & relationship): _____

◻ On-line directory; which one if you can recall: _____

◻ On-line search

◻ Other: _____

What brings you to therapy and why now? _____

_____

_____

What is your goal for therapy?

_____

_____

_____

4748 Chicago Ave. South, Suite 9 Minneapolis, MN 55407
PHONE / TEXT 612.323.7722 WEB www.renéedivine.com

HEALTH AND COUNSELING HISTORY

Other health care professionals you are currently working with: _____

_____

Please list any medications you are currently taking: _____

_____

What other medications have you taken in the past on a long-term basis? _____

_____

Have you seen a therapist or mental health professional in the past? ◻ Yes ◻ No

If yes, please describe: _____

When was your last physical? _____

How is your current physical health? ◻ Poor ◻ Unsatisfactory ◻ Satisfactory ◻ Good ◻ Very good

Please list any specific health problems you are currently experiencing: _____

_____

How often do you engage in physical activity and what do you do? _____

_____

How are your current sleeping habits? ◻ Poor ◻ Unsatisfactory ◻ Satisfactory ◻ Good ◻ Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

Please list any difficulties you experience with your appetite or eating patterns: _____

_____

What significant life changes or stressful events have you experienced recently: _____

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? ◻ Yes ◻ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ◻ Yes ◻ No

If yes, when did you begin experiencing this? _____

Do you regularly use alcohol? ◻ Yes ◻ No

If yes, in a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage recreational drug use? ◻Daily ◻Weekly ◻Monthly ◻Infrequently ◻Never

FAMILY INFORMATION

List current partner/spouse, children, and others in your current household:

Name	Relationship to You	Gender	Current Age

Do you have any concerns about your current living situation or environment? _____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	yes/no	_____
Mental Health Issues	yes/no	_____
Suicide Attempts	yes/no	_____
Chronic or significant physical illness	yes/no	_____
Physical/sexual/emotional or verbal abuse (circle)	yes/no	_____

PERSONAL STRENGTHS & BACKGROUND

What do you consider to be some of your strengths? _____

_____

What are you most proud of? _____

_____

What are a few personal challenges you manage? _____

_____

How important is spirituality in your life? Low ---------- High

What are your spiritual or religious beliefs? _____

_____

How do you describe your racial, ethnic, or cultural background?_____

_____

How would you describe your sexual orientation? _____

What is your occupation: _____ Employer: _____

What is your work life like? _____

_____

Describe your current support system or how you get support for your physical, spiritual, and emotional health (physical exercise, relaxation, friend and family connections, recreational, etc.):

_____

_____

Looking at your life what would you say are your:

Hopes_____

_____

Fears _____

_____

Joys _____

_____

Is there anything else you'd like to share with me that could be important or useful (Use the back for more space)?

_____

COUPLES QUESTIONS (please complete if you're doing therapy with your partner)

Rank the concerns you have in your relationship, the first being the most problematic:

1. _____
2. _____
3. _____

What have you already done to deal with the difficulties? _____

_____

_____

Have you received prior couples counseling related to any of the above problems? ☐Yes ☐No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

What was the outcome?

☐ Very successful ☐ Somewhat successful ☐ Stayed the same ☐ Somewhat worse ☐ Much worse

What are your strengths as a couple? _____

_____

_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does: _____

_____

Do either you or your partner drink alcohol or take drugs to intoxication? ☐Yes ☐No
If yes for either, who, how often and what drugs or alcohol? _____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?
☐Yes ☐No If yes for either, who how often and what happened?

_____

_____

Have either of you threatened to separate or divorce (if married) as a result of the current relationship problems?
☐Yes ☐No If yes, who? ____ Me _____ Partner ____ Both of us

If married, have either of you consulted with an attorney about divorce?
☐Yes ☐No If yes, who? ____ Me _____ Partner _____ Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?
☐Yes ☐No If yes, which of you has withdrawn? ____ Me _____ Partner _____ Both of us

How frequently have you engaged in sexual relations during the last month? _____ times

How enjoyable is your sexual relationship?
1 2 3 4 5 6 7 8 9 10
(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of sex?
1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress overall?
1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress in the relationship?
1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note pivotal/significant events in your relationship (e.g., one of you moved out, one of you cheated, etc.)

RELATIONSHIP OVER TIME