

Audra York Therapy, LLC
Audra York, LPC, MFT

4325 Laurel Street #230A
Anchorage, AK 99508

Phone: (907) 952-8532

Couples Intake Questionnaire

Date: _____

Referred By: _____

Partner #1

Last Name: _____ First Name: _____ MI: _____

Nickname: _____

Date of Birth: _____ SS #: _____

Gender: Male Female

Ethnic/Cultural Origins: _____

Allergies: _____

Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different from home): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

Work Phone: _____ Other: _____

Email Address: _____

Emergency Contact: _____ Ph: _____

Relationship: _____

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Partner #2

Last Name: _____ First Name: _____ MI: _____

Nickname: _____

Date of Birth: _____ SS #: _____

Gender: Male Female

Ethnic/Cultural Origins: _____

Allergies: _____

Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different from home): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

Work Phone: _____ Other: _____

Email Address: _____

Emergency Contact: _____ Ph: _____

Relationship: _____

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Insurance Information

Primary Insurance: _____

Insurance Phone: _____

Insurance ID Number: _____

Insurance Group Number: _____

Effective Date: _____

Client's relationship to Insured: _____

Insured Name- Last: _____, First: _____, MI: _____

Insured Street Address: _____

Insured City, State, Zip Code: _____

Insured Phone Number: _____

Insured Date of Birth: _____

Insured's Gender: Female Male

Insured's Employer: _____

Secondary Insurance: _____

Secondary Authorization Number: _____

Insured Name- Last: _____, First: _____, MI: _____

Client's relationship to Insured: _____

Insured Date of Birth: _____

Insurance ID Number: _____

Insurance Group Number: _____

Effective Date: _____

Insured's Employer: _____

Insured Street Address: _____

Insured City, State, Zip Code: _____

Insured Phone Number: _____

Insured's Gender: Female Male

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Any person have a history of self-harm or suicide? Yes No Who? _____

If yes, when was the last incident? _____

Any person have a family history of self-harm or suicide? Yes No

Any person have family history of mental illness or developmental delays? Yes No

If yes, please list relationships to you and illness and/or delays:

Any person have a family history of substance or alcohol use/abuse? Yes No

If yes, please describe: _____

Please list any possible traumas (e.g. abuse, domestic violence, car accidents, grief and loss, etc.):

Therapeutic Services

Briefly describe the reason for seeking therapeutic services:

What are you hoping to gain from therapy?

What strengths do you have?

Are you interested in medication? Yes No

Any other comments or concerns? _____

