Emotional Wellness
THERAPY
HEALING THROUGH CONNECTION. GROWING THROUGH CLARITY.

Suite 210, 7720 Elbow Dr SW
Calgary, AB T2V 1K2

(403) 710-3373
nelsoncd@shaw.ca
emotionalwellnesstherapy.ca

INTAKE FORM: COUPLES THERAPY

Thank you for taking the time to complete this form. Please include whatever feels manageable — we can explore the rest in our sessions. Your information is confidential and used only to support your relationship.

Date of Referral (yyyy-mon-dd): _____

How did you hear about Emotional Wellness Therapy?

Client Information

Name: _____

Pronouns *(optional):* _____

Address: _____

Postal Code: _____

Cell Phone: _____

Email: _____

Birth Date (yyyy-mon-dd): _____

Age: _____

Occupation: _____

Are there cultural, spiritual, or identity-related factors you would like me to consider in our work together?

Is there anything affecting your sense of safety or wellbeing as a couple that you would like me to be aware of?

Partner Information

Name: _____

Pronouns *(optional):* _____

Address: _____

Postal Code: _____

Cell Phone: _____

Email: _____

Birth Date (yyyy-mon-dd): _____

Age: _____

Occupation: _____

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Relationship Information

Relationship Status *(check one):*
( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed Other: _____

Length of time in current relationship: _____

How would you describe the quality of the relationship?
( ) Negative ( ) Poor ( ) Ambivalent ( ) Neutral ( ) Good ( ) Positive

Family Information

Children's names and ages *(indicate half- or step- if applicable)*:

- Child #1: _____ Age: _____
- Child #2: _____ Age: _____
- Child #3: _____ Age: _____
- Child #4: _____ Age: _____

Who currently lives in the home?

What do you feel the two of you are doing well in your relationship right now?

Clinical Issues I Support

(Please check any that feel relevant for your relationship)

- ( ) Communication difficulties or frequent conflict
- ( ) Emotional distance or disconnection
- ( ) Trust concerns or healing after breaches of trust
- ( ) Intimacy or sexual-connection concerns
- ( ) Anxiety or depression affecting the relationship
- ( ) Emotional overwhelm, shutdown, or dysregulation
- ( ) Trauma or attachment patterns impacting the relationship
- ( ) Parenting or co-parenting challenges
- ( ) Blended family or extended-family stress
- ( ) Life transitions (new baby, career changes, retirement)
- ( ) Grief, loss, or major stressors
- ( ) Financial strain or differences in financial habits
- ( ) Boundary setting and emotional safety

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- ( ) Cultural, religious, or value-based differences
- ( ) Neurodiversity within the relationship (ADHD, ASD, sensory needs)
- ( ) Feeling stuck, unsure, or uncertain about the future of the relationship

Your Relationship Story

What brings you to couples counselling at this time? How long has this been going on?

How is this affecting each of you and your relationship (communication, connection, daily life, work, family, parenting, etc.)?

Have there been any significant stressors or life events in the past 6 months that may be impacting your relationship?

What have you already tried to improve things between you? What helped, even a little?

Have either of you received counselling or other supports in the past?
(If yes, please include when, with whom, and the outcome.)

What coping strategies or communication approaches have been helpful for you as a couple?

What strengths do you each bring to the relationship? What do you appreciate about one another?

What would you like to accomplish through couples counselling? How will you know things are improving?

Thank you for connecting with Emotional Wellness Therapy.
I am honoured to support your relationship as we begin this work together.