DZ Counseling & Neurofeedback Training Services
Child, Adolescent, Adult, Couples & Family Counseling
501 Iron Bridge Road, Suite 15, Freehold, NJ 07728
Phone: 732-866-8611 ♦ Fax: 732-303-1221 ♦ www.dz-counseling.com

Daniel Zykorie, LCSW-S
Cathy Ielpi, MA, LPC
Jason Suleski, MSW, LCSW

FAMILY/COUPLES COUNSELING INTAKE FORM

Today's Date: _____

Here to see: ☐ **Daniel Zykorie, MSW, LCSW-S** ☐ **Cathy Ielpi, MA, LPC** ☐ **Jason Suleski, MSW, LCSW**

Client's Full Name: _____

Client's Full Address: _____

Client's date of birth: _____ Age: _____

Client's preferred personal contact phone number: _____ Leave Message. Y____ N____

Client's email address: _____

Partner's full name attending counseling with you: _____

By signing below, you are acknowledging the information contained on this form is accurate.

Print Client's Name: _____

Client's Signature: _____ Date: _____

1. Relationship status (check all that apply): ☐ Married ☐ Separated ☐ Divorced ☐ Dating
☐ Committed/Monogamous ☐ Living apart ☐ Cohabitating/living together

2. Length of time in current relationship: _____

3. As you think about the primary reason that brings you here, how frequently does it occur?

☐ No occurrence ☐ Occurs rarely ☐ Occurs sometimes ☐ Occurs frequently ☐ Occurs nearly always

4. As you think about the primary reason that brings you here, how would you rate your overall concern?

☐ No concern ☐ Little concern ☐ Moderate concern ☐ Serious concern ☐ Very serious concern

5. What do you hope to accomplish through counseling?

_____

6. What have you already done to deal with the difficulties?

_____

7. What are your greatest strengths as a couple?

_____

8. Please rate your current level of relationship happiness by selecting the number that corresponds with your current feelings about the relationship: (circle the number that applies)

1 = Extremely unhappy 2 3 4 5 6 7 8 9 10 = Extremely happy

9. Have you received prior couples counseling related to any of the above problems? Y____ N_____

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

11. If you have received prior couples counseling: N/A

When did this occur? _____ Where did this occur? _____

Who counseled you and for how long? _____

What were the problems that were addressed and what was the outcome?

_____

12. Have either you or your partner been in individual counseling before? Yes_____ No _____

13. Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

You: Alcohol- Yes _____ No _____ Drugs- Yes _____ No _____

Partner: Alcohol – Yes_____ No _____ Drugs- Yes _____ No _____

14. If married, has either of you threatened to separate or divorce because of the current relationship problems? Yes _____ No _____ N/A _____

15. Have either you or your partner struck, physically restrained, used violence against, or injured the other person? Yes _____ No _____

16. Do you perceive that either you or your partner has withdrawn from the relationship?

Yes_____ Who _____ No_____

17. If married, have either you or your partner consulted with a lawyer about divorce? Yes _____ No____ N/A_____

18. How frequently have you had sexual relations during the last month? _____

19. How satisfied are you with the frequency of your sexual relations?

1 = Extremely unsatisfied 2 3 4 5 6 7 8 9 10 = Extremely satisfied

20. How enjoyable is your sexual relationship? 1 = Extremely unpleasant 2 3 4 5 6 7 8 9 10 = Extremely pleasant

21. What is your current level of stress (overall)? 1 = No stress 2 3 4 5 6 7 8 9 10 = High stress

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

23. List your top three concerns that you have in your relationship with your partner (1 being the most problematic):

1._____ 2._____ 3._____

Thank you for completing this questionnaire. Please note that you will be asked to talk about your answers in appointments, but your partner will not be shown this form.

Client's Name: _____

Client's Signature: _____Date: _____

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Couples Counseling Policy

If you are here to address partner relationship challenges, it's important for you to understand what I, as your counselor, believe about relationships and marriage.

I do not have preconceived notions about whether you should stay together or part ways. I believe it is important to explore such questions openly, honestly, and thoroughly. Once your goals are established, I will work diligently to support you in achieving them, whatever they may be. You are entrusting me to use my professional judgment as it relates to individual confidences.

By signing this form, you are acknowledging that anything you communicate to me individually by phone, email, or any other means may be important to bring up and work on in a couples counseling sessions, and I reserve the right (but not the obligation) to do so.

Your Provider's Name: _____

Client's Name: _____

Client's Signature: _____

Partner's Name: _____

Date: _____