Couples Counseling Intake Form

Name: ____________________________________ Age: ______________

Name of Partner: ____________________________ Age: ______________

Relationship Status: (check all that apply)

- Married
- Separated
- Divorced
- Dating
- Cohabitating
- Living Together
- Living apart

Length of time in current relationship: _______________

How would you describe the reason for couples counseling, and how long has this been a problem?

____

____

What do you hope to accomplish through couples counseling?

____

____

What have you already done to deal with the difficulties?

____

____

What are your biggest strengths as a couple?

____

____

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

____

____

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 (check one)?

- Very Successful
- Somewhat successful
- Stayed the same
- Somewhat Worse
- Much worse

Has either of you threatened to separate or divorced (if married) as a result of the current relationship problems? ___Yes ___No

If yes, who? ____ Me ____Partner _____Both of us

Have you been in individual counseling before? ____Yes ____No
If so give a brief summary of concerns that you addressed:

____

____

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)

How well you do think you know your partner's world (for example, what they would order for coffee, what stresses them out at work, etc)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(Not well at all) (Extremely well)

How often do you share your fondness and admiration of your partner with them? (Circle one)

1 2 3 4 5 6 7 8 9 10
(Never) (All the time)

How well do you think you manage conflict as a couple? (Circle one)

1 2 3 4 5 6 7 8 9 10
(Not well at all) (Extremely well)

How would you rate the level of trust in your relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(No trust) (Explicit trust)

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(Extremely unpleasant) (Extremely pleasant)

How would you describe your childhood? ___ Good ___ Fair ___ Poor

How would you describe your parents' relationship (or the most influential relationship you saw between adults as a child)? ____

____

What is your relationship with your family of origin like today? ___ Good ___ Fair ___ Poor

Do you have children? ___ Yes ___ No

If yes, are your children living with you? ___ Yes ___ No

Do you have any parenting concerns that are impacting your relationship? ___ Yes ___ No

What/who is your support system? ____

What do you do for fun or recreation? ____

Do you currently have thoughts of death or suicide? ___ Yes ___ No

If yes, have you ever done anything or planned out a way to hurt yourself? ___ Yes ___ No

If yes, please give details: ____

Do either you or your partner drink alcohol to intoxication or take drugs in intoxication? ___Yes ___No

If yes, please give details: ____

____

Has there been hitting, physical restraint, violence, or injury within your relationship? ___Yes ___No

If yes, who initiated it, how often has it happened, and what happened?

____

____

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).

Complete Satisfaction

No Satisfaction

when you met/began dating *Today*

Relationship over time

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.