**Couples Counseling Intake Form** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_

Relationship Status: (check all that apply) Length of time in current relationship\_\_\_\_\_\_

\_\_Married \_\_Dating \_\_Divorced

\_\_Separated \_\_Cohabitating

As you think about the primary reason that brings you here, how would you rate its frequency & your overall level of concern at this time?

**Concern** **Frequency**

* \_\_\_No concern \_\_\_No occurrence
* \_\_\_Moderate Concern \_\_\_Occurs Rarely
* \_\_\_Serious Concern \_\_\_Occurs sometimes \_\_\_ Occurs frequently

What do you hope to accomplish through counseling?

What have you already done to deal with the difficulties?

What are your biggest 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

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 counseling before? Yes no Please indicate where, when and outcome: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If yes for either, who, how often, and what drugs / alcohol?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have either you or your partner ever struck, physically restrained, used violence against or injured the other person? Please explain:

Has either of you threatened divorce? Yes No (who?\_\_\_\_\_\_) Contacted a lawyer? Yes No (who\_\_\_\_)

Do you perceive that either you or your partner has withdrawn from the relationship? If yes, who?

How frequently have you had sexual relations during the last month? \_\_\_\_\_\_\_ times

What is your current level of stress overall? 1-10 \_\_\_\_\_\_\_\_ Stress in the relationship? 1-10 \_\_\_\_\_\_\_

What are your spiritual / religious beliefs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you attend religious services? If yes, where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often\_\_\_\_\_\_\_\_\_\_

What was your parent or guardian’s marriage like, as you were growing up? (what did you see)

RANK ORDER

the top 3 concerns you have regarding this relationship (1 being the most problematic):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with WHEN YOU MET. Note pivotal / significant events in your relationship timeline

*Complete Satisfaction*

100%

**Level**

**Of**

**satisfaction**

50%

0%

**TIME>>>>>>>>> Current Day**

*NO Satisfaction*

**When you met Relationship TIMELINE CURRENT Day**

*Thank you for completing this. You may keep this private & please bring it with you to your first appointment with the counselor. Newdaymv.com Mountain View MO Counseling Center, LLC*