Couples Intake Form

**Name:**

**Date:**

**Name of Partner:**

**Relationship Status:** (check those that apply)

* Married
* Separated
* Divorced
* Dating
* Cohabitating
* Living Together
* Living Apart

**Length of Time in Current Relationship:**

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

|  |  |
| --- | --- |
| ***Concern:***   * No Concern * Little Concern * Moderate Concern * Serious Concern * Very Serious Concern | ***Frequency:***   * No Occurrence * Occurs Rarely * Occurs Sometimes * Occurs Frequently * Occurs Nearly Always |

**What do you hope to accomplish through counseling/therapy?**

**Have you received any couple counseling in the past? If yes, when and by whom? What was the outcome?**

**Have either you or your partner been in *individual* counseling before?** (check those that apply)

* Yes
* No

**If so, give a brief summary of concerns that you addressed.**

**Do either you or your partner frink alcohol to intoxication or take drugs to intoxication?** (check those that apply)

* Yes
* No

**If yes for either, who, how often and what drugs or alcohol do you take/drink?**

**How satisfied are you with the frequency of your sexual relations?** (circle one)

1 2 3 4 5 6 7 8 9 10

(extremely unsatisfied) (extremely satisfied)

**What is your current level of stress (overall)?** (circle one)

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

**What is your current level of stress (in the relationship)?** (circle one)

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

**What are your top three concerns?**

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.