

Couples Counseling Initial Intake Form

Please note that while you will be asked to talk about your answers in sessions, your partner will not be shown this form.

Name: _____ Date _____

Phone: _____ May I leave a message? Y / N Age: _____

Do you have a religious or spiritual preference? Y / N

If yes please explain: _____

Is it acceptable to email you? If so, what is your email address?

Relationship Status: (check all that apply)

- Married Living Together Divorced
 Separated Living Apart Dating

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. (Circle one)

1 2 3 4 5 6 7 8 9 10

(extremely happy)

(extremely unhappy)

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, with whom: _____

Where: _____ Length of treatment _____

Outcome: _____

Have either of you been in individual counseling before? Yes No

If so, give a brief summary of concerns you addressed:

Do either of you drink alcohol or take drugs to intoxication? Yes No

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

Do you ever wish your partner would cut back on his/her drinking or drug use? Yes No

Have either of you struck, physically restrained, used violence against or injured the other person?

Yes No

If yes, who, how often and what happened?

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems? Yes No

If yes, who? Me Partner Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

Yes No If yes, who? Me Partner Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? Yes No

If yes, who? Me Partner Both of us

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10

(extremely unpleasant)

(extremely pleasant)

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

1 2 3 4 5 6 7 8 9 10

(extremely unpleasant)

(extremely pleasant)

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)

Rank the order of the top three concerns you have in your relationship with your partner (1 being the most problematic)

1. _____

2. _____

3. _____