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Couples Counseling Initial Intake Form

Name:____ Date: ______________________________

Name of Partner: ____

Relationship Status: (check all that apply)

□ Married □ Separated □ Divorced □ Dating □ Cohabitating □ Living together □ Living apart

Length of time in current relationship: ____

How long did you know your spouse before marriage? ______________________________________

Length of steady dating with your spouse ____

Length of engagement ____

Give brief information about any previous marriages
____
____
____

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?
____
____
____

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 (1 is extremely unhappy) (10 is extremely happy)

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: __________________

Issues treated:

____
____
____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in individual counseling before? □ Yes □ No

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

____
____
____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? □ Yes □ No

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

____
____
____

Do you have any concerns about either you or your partner regarding other compulsive / addictive behavior (i.e. gambling, sexual, spending, etc.)? □ Yes □ No

If yes for either, who, how often and what compulsive / addictive behavior?

____
____
____

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

□ Yes □ No

If yes for either, 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?

If yes, who? □ Me □ Partner □ Both of us

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

If yes, who? □ Me □ Partner □ Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

If yes, which of you has withdrawn? □ Me □ Partner □ Both of us

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

How enjoyable is your sexual relationship?

1 2 3 4 5 6 7 8 9 10 (1 is extremely unpleasant; 10 is extremely pleasant)

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

1 2 3 4 5 6 7 8 9 10 (1 is extremely unsatisfied; 10 is extremely satisfied)

What is your current level of stress (overall)?

1 2 3 4 5 6 7 8 9 10 (1 is no stress; 10 is high stress)

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

1 2 3 4 5 6 7 8 9 10 (1 is no stress; 10 is high stress)

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

1. ____
2. ____
3. ____