Couples Initial Intake Form

Name:	Date:		
Name of Partner: _			
Relationship Status:	(check all tha	at apply)	
🗆 Married	Dating	Separated	
Living apart		Divorced	Living together
Length of time in c	urrent relatior	nship:	
		reason that brings yo of concern at this p	ou here, how would you rate its oint in time?
Concern			Frequency
No concern			No occurrence
🗆 Little concern			Occurs rarely
Moderate conce	rn		Occurs sometimes
Serious concern			Occurs frequently
Very serious cor	ncern		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
(extremel happy)	y unhapı	oy)							(extremely

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? \square Yes \square No

If yes, when: \	Where:
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By whom: ______ Length of treatment:

Problems treated:

What was the outcome (check one)?

 \Box Very successful \Box Somewhat successful \Box Stayed the same \Box Somewhat worse \Box Much worse

Have either you or your partner been in individual counseling before? \Box Yes \Box 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?

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

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

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 Me Partner Both of us Do you perceive that either you or your partner has withdrawn from the relationship? If yes, which of you has withdrawn?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 sex during the last month? times How enjoyable is your sexual relationship? (Circle one) (extremely unenjoyable) (extremely enjoyable) How satisfied are you with the frequency of your sexual relations? (Circle one) (extremely unsatified) (extremely satisfied) What is your current level of stress (overall)? (Circle one) (no stress) (high stress) What is your current level of stress (in the relationship)? (Circle one) (no stress) (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. ₋	

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

beginning

now

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.