**Couples Counseling Initial Intake Form**

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

Name: DOB: Address:

Phone: Voicemail/Text messages OK? Y / N

Is it acceptable to email you? If so, email address: Emergency Contact:

Relationship Status: (check all that apply)

Married Living Together Divorced Coparenting

Separated Living apart Dating

What is the reason you are seeking counseling today?

What do you hope to accomplish through couples counseling?

What have you already done to deal with the difficulties?

What are your biggest strengths as a couple?

Do you and your partner have children? If yes, please explain the family dynamics (biological children, blended family, parenting styles, etc.)

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

(extremely unhappy) (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? Y/ N

 If yes, with whom: Length of treatment: Outcome: \_\_\_\_\_\_\_\_

Have you been in individual counseling before? Yes No If so, give a brief summary of concerns you addressed.

Do you have a history of trauma that has not been treated? Trauma includes emotional, physical, or sexual abuse, grief, attachment/abandonment, combat, natural disasters.

Do either you or your partner drink alcohol or take drugs to intoxication? Yes No N/A

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

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

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Do you perceive that either you or your partner has withdrawn from the relationship?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

Any other information you would like to share? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Printed name of client Date signed

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 Signature of client