

Couples Counseling Initial Intake Form

Each of you should fill out a form separately

Name: _____ Date _____

Name of Partner: _____

Relationship status: circle all that apply

Married Separated Divorced Dating Living Together Living Apart

Engaged

Length of time in current relationship: _____

What is the primary reason that brings you here

how would you rate its frequency

and your overall level of concern at this point in time?

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 on a scale of 1-10 with 10 being happiest. _____

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: _____

length of treatment _____

What was the outcome? Very successful Somewhat successful
 Stayed the same Somewhat worse Much worse

**Have either you or your partner ever been in, or currently in individual counseling?
If so, give a brief summary of concerns addressed in individual counseling.**

**Briefly describe your role models growing up of couple relationships in your
parents:**

**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?

**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 were charges ever filed?

**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

**Do you perceive that either you or your partner has withdrawn from the
relationship? Yes No Me Partner Both of us**

**How enjoyable is your sexual relationship on a scale of 1-10 with 10 extremely
enjoyable?**

**How satisfied are you with the frequency of your sexual relations? 1-10 with 10
being extremely satisfied. _____**

**What is your current level of stress OVERALL IN LIFE? 1-10 with 10 being high
stress**

**What is your current level of stress IN THE RELATIONSHIP? 1-10 with 10 being
high stress**

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

1.

2.

3.

**Please print this and bring it to the first session with you.
Thank you.**