

**Couples Counseling Initial Intake Form**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Partner:** \_\_\_\_\_

**Relationship Status:** (check all that apply)

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Married   | <input type="checkbox"/> Cohabiting      |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Living together |
| <input type="checkbox"/> Divorced  | <input type="checkbox"/> Living apart    |
| <input type="checkbox"/> Dating    |  |

**Length of time in current relationship:** \_\_\_\_\_

**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?**

- |   |   |
|---|---|
| <b><i>Concern</i></b>                         | <b><i>Frequency</i></b>                       |
| <input type="checkbox"/> No concern           | <input type="checkbox"/> No occurrence        |
| <input type="checkbox"/> Little concern       | <input type="checkbox"/> Occurs rarely        |
| <input type="checkbox"/> Moderate concern     | <input type="checkbox"/> Occurs sometimes     |
| <input type="checkbox"/> Serious concern      | <input type="checkbox"/> Occurs frequently    |
| <input type="checkbox"/> Very serious concern | <input type="checkbox"/> 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?**

---

---

---



**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?**

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**Do you perceive that either you or your partner has withdrawn from the relationship?** Yes  No

If yes, which of you has withdrawn?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?** (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)

**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**

**Relationship over time**

*When you met/began dating*

*Current*

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.