

**Couples Counseling Initial Intake
Form**



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Full Name: _____

Date: _____

Name of Partner: _____

Relationship Status:

- Married
- Separated
- Divorced
- Dating
- Cohabiting
- Living apart

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?

- Concern***
- No concern
 - Little concern
 - Moderate concern
 - Serious concern
 - Very serious concern

- Frequency***
- No occurrence
 - Occurs rarely
 - Occurs sometimes
 - Occurs frequently
 - Occurs nearly always

Have you received prior couples counseling related to any of the above problems? Yes / No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

What was the outcome?

- 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?

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Do you perceive that either you or your partner has withdrawn from the relationship?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If yes, which of you has withdrawn?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 relationships during the last month? _____times

-3-

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 you have in your relationship with your partner (1 being the most problematic):

1. _____
2. _____
3. _____

-4-

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 individual assessment for couples. Please note that you will be asked to talk about your answers in sessions, but your partner will not be shown this form.