Couples Intake Form

Demographics

Partner 1:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Partner 2:

Name: _____ Date: _____

Address: ☐ Same as above _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Referred by: _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Marital Status: Dating Engaged Married (___years married) Separated Divorced (circle one)

Children:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

**If children are stepsiblings or partial siblings please indicate next to their name*

Mental Health:

Has anyone in the immediate family currently or historically been suicidal? ☐ Yes ☐ No
If yes, who and when?_____

Has anyone in the immediate family been hospitalized for mental health related issues? ☐ Yes ☐ No
If yes, who and when?_____

Is anyone in the immediate family currently receiving counseling services with another professional?
☐ Yes ☐ No
If yes, who and for how long?_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? ☐ Yes ☐ No

Who, how often, and what substances are used? _____

Has anyone in the family ever struck, physically restrained, used violence against, or injured any person within the family? ☐ Yes ☐ No

If yes, please explain: _____

_____

Reasons for Seeking Couples Counseling:

_____

_____

How would you know that your time in therapy has been successful? What would look different in your relationship?
_____

_____

Have either of you considered separation or divorce as a result of current marital problems?
☐ Yes ☐ No
If yes, when? _____ Have you had any previous couples counseling? ☐ Yes ☐ No

Name of therapist: _____ Date of counseling: _____

Would you be willing to sign a release of information to talk with previous counselor? ☐ Yes ☐ No

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Partner Inventory **Partner 1**: (name) _____

List some strengths of your relationship: _____

_____

List some weaknesses of your relationship: _____

_____

Indicate anything that pertains to you <u>presently</u>:

- ☐ Anger
- ☐ Education concerns
- ☐ Sexual problems
- ☐ Work problems
- ☐ Drug use
- ☐ Loneliness
- ☐ Relationship problems
- ☐ Fatigue
- ☐ Lack of ambition
- ☐ Stomach problems
- ☐ Financial concerns
- ☐ Concerns about appearance
- ☐ Suicidal thoughts
- ☐ Fears about the future
- ☐ Problems with friends
- ☐ Problems concentrating
- ☐ Nightmares
- ☐ Quick temper
- ☐ Concerns about my thoughts
- ☐ Concerns about parenthood
- ☐ Health problems
- ☐ Concerns about age
- ☐ Nervousness
- ☐ Unable to relax
- ☐ Concerns about making decisions
- ☐ Stress
- ☐ Problems with self-esteem
- ☐ Concerns about sexual orientation
- ☐ Concerns about sexual desire
- ☐ Concerns about sexual satisfaction
- ☐ Physical abuse
- ☐ Anxiety
- ☐ Marital separation
- ☐ Lack of energy
- ☐ Feelings of inferiority
- ☐ Lack of appetite
- ☐ Sexual abuse
- ☐ Concerns about children
- ☐ Concerns about career choices
- ☐ Concerns about weight
- ☐ Shyness
- ☐ Legal problems
- ☐ Problems with self-control
- ☐ Memory difficulty
- ☐ Lack of sleep
- ☐ Under/Over-eating
- ☐ Problems with alcohol use
- ☐ Unhappiness
- ☐ Depression
- ☐ Headaches
- ☐ Fear
- ☐ Other: _____

Indicate anything that has happened to you in the <u>past three years</u>:

- ☐ Death of a spouse/partner
- ☐ Death of another family member
- ☐ Relationship Problems
- ☐ Changes in relationship status
- ☐ Family Problems (children, in-laws)
- ☐ Loss of Job
- ☐ Financial Problems
- ☐ Move to another city or state
- ☐ Major illness or injury–yourself
- ☐ Major illness or injury–family member
- ☐ Legal Problems
- ☐ Other: _____

Partner Inventory **Partner 2**: (name) _____

List some strengths of your relationship: _____

_____

List some weaknesses of your relationship: _____

_____

Indicate anything that pertains to you <u>presently</u>:

- ☐ Anger
- ☐ Education concerns
- ☐ Sexual problems
- ☐ Work problems
- ☐ Drug use
- ☐ Loneliness
- ☐ Relationship problems
- ☐ Fatigue
- ☐ Lack of ambition
- ☐ Stomach problems
- ☐ Financial concerns
- ☐ Concerns about appearance
- ☐ Suicidal thoughts
- ☐ Fears about the future
- ☐ Problems with friends
- ☐ Problems concentrating
- ☐ Nightmares
- ☐ Quick temper
- ☐ Concerns about my thoughts
- ☐ Concerns about parenthood
- ☐ Health problems
- ☐ Concerns about age
- ☐ Nervousness
- ☐ Unable to relax
- ☐ Concerns about making decisions
- ☐ Stress
- ☐ Problems with self-esteem
- ☐ Concerns about sexual orientation
- ☐ Concerns about sexual desire
- ☐ Concerns about sexual satisfaction
- ☐ Physical abuse
- ☐ Anxiety
- ☐ Marital separation
- ☐ Lack of energy
- ☐ Feelings of inferiority
- ☐ Lack of appetite
- ☐ Sexual abuse
- ☐ Concerns about children
- ☐ Concerns about career choices
- ☐ Concerns about weight
- ☐ Shyness
- ☐ Legal problems
- ☐ Problems with self-control
- ☐ Memory difficulty
- ☐ Lack of sleep
- ☐ Under/Over-eating
- ☐ Problems with alcohol use
- ☐ Unhappiness
- ☐ Depression
- ☐ Headaches
- ☐ Fear
- ☐ Other: _____

Indicate anything that has happened to you in the <u>past three years</u>:

- ☐ Death of a spouse/partner
- ☐ Death of another family member
- ☐ Relationship Problems
- ☐ Changes in relationship status
- ☐ Family Problems (children, in-laws)
- ☐ Loss of Job
- ☐ Financial Problems
- ☐ Move to another city or state
- ☐ Major illness or injury–yourself
- ☐ Major illness or injury–family member
- ☐ Legal Problems
- ☐ Other: _____