

**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?**

- | <i>Concern</i>                                | <i>Frequency</i>                              |
|---|---|
| <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**Do you perceive that either you or your partner has withdrawn from the relationship?** Yes  No

If yes, which of you has withdrawn?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)