R³ Counseling & Consulting Services

COUPLES COUNSELING INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Date: _____/_____/_____

Name: _____ DOB: ____/____/____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Okay to leave messages? □ Yes □ No

Email Address: _____

Ethnicity: □ American Indian or Alaskan Native □ Asian American □ Black/African American
□ Hispanic □ Multiracial □ Pacific Islander □ White □ Other _____

US Citizen? □ Yes □ No If no, immigration status: _____

Schooling (highest level completed):

□ Elementary school □ High School □ College □ Graduate School □ Trade School □ GED

Persons living with you:

Name	Age	Relationship

Who referred you: _____

Couples Counseling Initial Intake Form

Name:_____ **Date**: _____

Name of Partner:_____

Relationship Status: (check all that apply)

□ Married
□ Separated
□ Divorced
□ Dating
□ Cohabitating
□ Living together
□ 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

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 by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

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: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

_____

What was the outcome (check one)?

□ 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 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.