

COUPLES THERAPY INTAKE FORM

Please complete this form individually

First name: _____ Last name: _____

Age: _____ Birthdate: _____ Sex/Gender: _____

Ethnicity: _____ Religion: _____

Marital status (dating, married, cohabiting, separated, divorced): _____

Number of children: _____ Ages of Children: _____

Home address: _____

Who lives with you at this address? _____

Cell phone: _____ Home phone: _____

Work phone: _____ Email: _____

Name of emergency contact: _____ Phone: _____

EMPLOYMENT INFORMATION

Employed full-time part-time

Position: _____ Employer: _____

Unemployed laid off terminated medical leave disabled

Other: _____

PSYCHIATRIC AND MEDICAL HISTORY

Please list any *psychiatric* diagnoses you have received.

Have you ever been hospitalized for psychiatric reasons?

Yes

No

If yes, please describe when and where, and for what reasons.

Please list the medications you currently take, and why they were prescribed:

Please list any *medical* diagnoses you have received:

Name of Physician: _____ Phone: _____

Name of Psychiatrist/Psychologist: _____ Phone: _____

Name of Therapist/Social Worker: _____ Phone: _____

MENTAL HEALTH COUSELING HISTORY

Have you received *couples counseling* before? Yes No

If yes, when? _____

With whom? (current partner, previous partner, etc.) _____

Length of treatment: _____

Problems addressed: _____

Describe the effectiveness of the couples counseling:

Very effective Somewhat effective No change Issues worsened

Have you ever received *individual counseling* before? Yes No

Length of treatment: _____

Problems addressed: _____

Describe the effectiveness of your individual counseling:

Very effective Somewhat effective No change Issues worsened

YOUR HABITS

Please describe how much/often you participate in the following:

Smoking: Never Seldom Regularly Constantly
 Would like to cut back Others want me to cut back

Gambling: Never Seldom Regularly Constantly
 Would like to cut back Others want me to cut back

Overspending/shopping: Never Seldom Regularly Constantly
 Would like to cut back Others want me to cut back

Drinking: Never Seldom Regularly Constantly
 Would like to cut back Others want me to cut back

Drug use: Never Seldom Regularly Constantly
 Would like to cut back Others want me to cut back

Overeating/Bingeing/Purging/Restricted eating: Never Seldom Regularly
 Constantly Would like to cut back Others want me to cut back

Social Media/Gaming/Electronic Devices: Never Seldom Regularly
 Constantly Would like to cut back Others want me to cut back

Sex (with partner): Never Seldom Regularly Constantly
 Would like to cut back Others want me to cut back

Sex (with others): Never Seldom Regularly Constantly
 Would like to cut back Others want me to cut back

Other _____: Never Seldom Regularly
 Constantly Would like to cut back Others want me to cut back

Other _____: Never Seldom Regularly
 Constantly Would like to cut back Others want me to cut back

YOUR STRESS

What is your current level of stress overall? (circle one)

[No stress] 1 2 3 4 5 6 7 8 9 10 [Extremely stressed]

Check off the areas of your life where you are encountering stressful situations.

Financial problems

Describe: _____

Health issues

Describe: _____

Legal issues/crime/community violence

Describe: _____

Race/ethnic cultural issues

Describe: _____

Family conflict

Describe: _____

Social problems

Describe: _____

Educational or professional difficulties

Describe: _____

Housing issues

Describe: _____

Grief, bereavement or loss

Describe: _____

Parenting issues

Describe: _____

Elder care issues

Describe: _____

Other

Describe: _____

YOUR RELATIONSHIP

How long have you been dating, married, cohabiting, separated or divorced from the person with whom you are seeking therapy? _____

Why are you seeking help at this time? (Was there a particular event or problem that led to this decision?)

Whose idea was it to come to therapy?

What are your expectations for couples counseling?

What would you like to learn/achieve through therapy? (check all that apply):

- Better communication
- Problem solving
- Conflict resolution
- More quality time together
- More autonomy
- More hobbies
- More social connections
- More separate friends and interests
- More respect/understanding
- More trust
- Resolve individual issues
- Power and control issues
- Increased sharing of chores/household responsibilities
- Increased sharing of financial responsibilities/contributions
- Parenting skills
- Better sharing of parenting responsibilities
- Help with children's behavior
- More intimacy (sexual)
- More intimacy (emotional)
- Other (specify): _____
- Other (specify): _____

Have either you or your partner restrained, harmed or injured the other person?

Yes No

If yes for either partner, who, how often, and what happened?

If married, have either of you threatened to separate/divorce as a result of the current relationship problems? Yes No

If yes, who? ___ Me ___ Partner ___ Both of us

Have either of you consulted with a lawyer about divorce? Yes No

If yes, who? ___ Me ___ Partner ___ Both of us

Have you or your partner ever emotionally or physically cheated on each other?

Yes No Unsure

If yes, who? ___ Me ___ Partner ___ Both of us

What are the top three concerns that you have about your relationship?

1. _____
2. _____
3. _____

What, if anything, have you tried to address these difficulties? How successful were you?

What are your biggest strengths as a couple?

What are the largest areas for improvement?

What is your current level of satisfaction and fulfillment in this relationship? (circle one)

[Extremely unsatisfied] 1 2 3 4 5 6 7 8 9 10 [Extremely satisfied]

What is your current level of stress in the relationship? (circle one)

[No stress] 1 2 3 4 5 6 7 8 9 10 [Extremely stressed]

How important is it to you to improve the quality of your relationship? (circle one)

[Not important at all] 1 2 3 4 5 6 7 8 9 10 [Extremely important]

How willing are you to make your relationship a priority in your life? (circle one)

[Unwilling] 1 2 3 4 5 6 7 8 9 10 [Extremely willing]

List three steps you could take to improve the relationship, regardless of what your partner does.

Is there anything else that you would like to mention?