

Couples Counseling Intake Form

Name: _____ Age: _____ Date of Birth: ____/____/____

Address: _____
Street and Number City State Zip

Phone: _____ May we leave a message? Yes No

E-mail: _____ May we text message you? Yes No

May we email you? Yes No

In case of emergency please notify: _____

Phone: _____ Relationship to client: _____

How did you hear about us? Psychology Today Yelp Facebook/Social Media
 Referred by: _____
 Insurance Walked by Other: _____

Relationship Information

1. Please indicate your relationship status: (*check all that apply*) Married/Partnered Dating
 Separated Divorced Cohabiting In a relationship Other: _____

2. Briefly tell us about the issues/concerns that have brought you here. Why are you seeking couples counseling at this time?

3. Have you been married or partnered before? Yes No (if yes, # of times?) _____

4. How long have you and your current partner been in this relationship? _____

5. Are you and your partner presently living together? Yes No

6. Are you and your partner engaged to be married? Yes No

If yes, when? _____

If not, is this a source of conflict? Yes No Maybe

7. Please fill in the percentages to indicate your amount of satisfaction and commitment:

I am _____% committed to staying in our relationship.

I am _____% satisfied in our relationship.

8. On a scale from 0 to 6, how would you rate your current level of happiness in your relationship?

0	1	2	3	4	5	6
Extremely unhappy	Fairly unhappy	A little unhappy	Happy	Very happy	Extremely happy	Perfect

9. *If neither you nor your partner has children, please move on to Question #10.* If either you or your partner have children, please fill out the following information for each child:

Child's name	Age	Whose child?	Lives with whom?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

10. Please check any current or past topics that are *relevant to your relationship*. If not applicable, leave blank. (C = currently P = in the past)

- | | | |
|------------------------------------------------------------|-------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Alcohol/problematic substance use | <input type="checkbox"/> Finances | <input type="checkbox"/> Past relationships |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Flirting with others | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Gambling | <input type="checkbox"/> Physical attraction |
| <input type="checkbox"/> Commitment | <input type="checkbox"/> Getting engaged | <input type="checkbox"/> Fertility/Pregnancy |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Honesty | <input type="checkbox"/> Sex life |
| <input type="checkbox"/> Conflict resolution | <input type="checkbox"/> Housework/chores | <input type="checkbox"/> Social life |
| <input type="checkbox"/> Controllingness | <input type="checkbox"/> Infidelity | <input type="checkbox"/> Spirituality/religion |
| <input type="checkbox"/> Criticism | <input type="checkbox"/> Intimacy/affection | <input type="checkbox"/> Stubbornness |
| <input type="checkbox"/> Culture/Identity | <input type="checkbox"/> Irresponsible behavior | <input type="checkbox"/> Technology use |
| <input type="checkbox"/> Defensiveness | <input type="checkbox"/> Jealousy | <input type="checkbox"/> Time together |
| <input type="checkbox"/> Degrading comments | <input type="checkbox"/> Love | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Lying | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Emotional closeness | <input type="checkbox"/> Negativity | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Family responsibilities | <input type="checkbox"/> Outside interests | <input type="checkbox"/> Working too much |
| | <input type="checkbox"/> Parenting | |

11. *If conflicts or fights are NOT an issue, please move on to Question #12.* If they are an issue, please select the appropriate response for each:

Behavior	By Me:	By Partner:	Source of Conflict?	
Apologizing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Becoming silent/withdrawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Begging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Being mean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breaking things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bringing up the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Criticizing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cruel accusations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leaving the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Making peace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Moodiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name-calling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Not listening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical threats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sarcasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Screaming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Slamming doors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speaking irrationally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speaking rationally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sulking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threatening breaking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threatening taking the kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Throwing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Verbal abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Yelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

12. Do you feel as though your temper adversely affects your relationship? Yes No
 Your partner's temper? Yes No
13. Do you feel as though your mood adversely affects your relationship? Yes No
 Your partner's mood? Yes No
 If you answered yes to either, which moods? _____
14. Have you ever been verbally abusive to your partner? Yes No I don't know
 Has your partner ever been verbally abusive to you? Yes No I don't know
15. Have you every been physically abusive to your partner? Yes No I don't know
 Has your partner ever been physically abusive to you? Yes No I don't know
16. ***It is our policy that if an affair or inappropriate outside relationship is revealed, that the individual will be expected to disclose this information during the course of couples counseling.***
 Have you ever had an affair (or inappropriate outside relationship) during your current relationship? Yes No If yes, is the affair current? Yes No
 Has your partner ever had an affair (or inappropriate outside relationship) during your current relationship? Yes No If yes, is the affair current? Yes No
17. Have you ever been in couples therapy before? Yes No
 If yes, what was the therapist's name? _____
 What was the experience like? _____

Individual Information

18. Please check any current or past topics that are ***relevant to you individually***:

- | | |
|-----------------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Eating disorders/body image | <input type="checkbox"/> Culture/identity |
| <input type="checkbox"/> Academics or work | <input type="checkbox"/> Spirituality/religion |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Dating |
| <input type="checkbox"/> Outside interests (extracurricular) | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Sexual health |
| <input type="checkbox"/> Technology use | <input type="checkbox"/> Coming out |
| <input type="checkbox"/> Stress/anxiety | <input type="checkbox"/> Transitioning |
| <input type="checkbox"/> Phobias (type(s): _____) | <input type="checkbox"/> Fertility/pregnancy |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Chronic pain/illness (type(s): _____) | <input type="checkbox"/> Infidelity |
| <input type="checkbox"/> Childhood abuse (i.e. physical, sexual, emotional) | <input type="checkbox"/> Domestic violence/abuse |
| <input type="checkbox"/> Sexual assault/rape | <input type="checkbox"/> Family (ie. divorce, alcoholism) |
| <input type="checkbox"/> _____ Recently (when: _____) | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> _____ In the past | <input type="checkbox"/> Family |
| <input type="checkbox"/> Alcohol/problematic substance use | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Parent |
| <input type="checkbox"/> Death of someone close | <input type="checkbox"/> Significant other |
| <input type="checkbox"/> _____ Recently (when: _____) | <input type="checkbox"/> Roommate |
| <input type="checkbox"/> _____ In the past | <input type="checkbox"/> Coworker |
| <input type="checkbox"/> Other: _____ | |

19. Are there any physical health concerns of yours that may be relevant to couples counseling?

20. Current medications (all, including herbal): _____

21. Are you currently working with a psychiatrist? Yes No
If yes, what is your psychiatrist's name? _____ Phone: _____
What is the psychiatrist treating you for? _____

22. Have you been on any medications in the past for mental health issues? Yes No
If yes, please list: _____

23. Have you previously seen a therapist? Yes No
Who/Where? _____ How long ago? _____
For what types of issues? _____

24. Are you currently/recently seeing any kind of therapist/healer? _____

25. Have you ever been hospitalized for physical or mental health issues? Yes No
If yes, briefly describe: _____
Have you had any previous suicide attempts? Yes No
If yes, briefly describe: _____

26. If you are currently experiencing any of the following symptoms, please rate them using the number key below:

<i>Never 0</i>	<i>Seldom 1</i>	<i>Often 2</i>	<i>Always 3</i>
___ Difficulty concentrating			___ Memory loss or blackouts
___ Crying			___ Difficulty sleeping
___ Missing work/class			___ Stealing
___ Feeling helpless			___ Anger
___ Negativity			___ Jealousy
___ Feeling uptight/tense			___ Eating binges
___ Worrying			___ Drinking heavily
___ Feeling hopeless			___ Problematic drug use
___ Feeling afraid			___ Feelings of guilt
___ Lying to others			___ Withdrawing socially
___ Feeling out of control			___ Sexual preoccupation/obsessions
___ Feelings of self-doubt			___ Low sex drive
___ Injuring self			___ Suicidal thoughts
___ Loneliness			___ Physical symptoms (i.e. headaches, digestive)
___ Nervousness around others			List: _____
___ Other: _____			Have you seen a health care provider for these? ___

Is there anything else you'd like us to know about you? _____

Insurance Information: Please fill out the following information if you are paying for the counseling sessions through insurance. These questions refer to the information currently on file with the insurance company.

1. Member name: _____ 2. Member ID#: _____
3. Gender: _____ 4. DOB: _____
5. Address: _____
Street and Number City State Zip