

# COUPLES INTAKE FORM

*Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Your Spouse/Partner: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (        )        -        May I leave a msg?  Yes  No  
Cell/Other Phone: (        )        -        May I leave a msg?  Yes  No  
E-mail: \_\_\_\_\_ May I email you?  Yes  No

Referred by: \_\_\_\_\_

Can I thank them for connecting you with me?  Yes  No

Relationship Status: (check all that apply)

Married  Separated  Divorced  Dating  Living Together  Living Apart

Length of time in current relationship: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Have you had previous therapy?

No  Yes, previous therapist's name: \_\_\_\_\_

What was the outcome (check one)?

Very successful  Somewhat successful  Stayed the same  Somewhat worse  Much worse

**OCCUPATIONAL/SCHOOL INFORMATION:**

Are you currently employed?

No  Yes If yes, who is your current employer/position? \_\_\_\_\_

If yes, are you happy at your current position? \_\_\_\_\_

Are you currently a student?  No  Yes, school's name: \_\_\_\_\_

Please list any work-related/school stressors, if any: \_\_\_\_\_

**SPIRITUAL INFORMATION:**

Is spirituality part of your life?  Yes  No

If yes, what is your faith?

Could spirituality discussions be part of the counseling process?  Yes  No

**HEALTH INFORMATION:**

1. In the last year, have you experienced any significant life changes or stressors? If yes, please explain.

\_\_\_\_\_

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

\_\_\_\_\_

3. Are you currently taking prescribed psychiatric medication (antidepressants or others)?

No  Yes If Yes, please list: \_\_\_\_\_

4. Are you having any problems with your sleep habits?  No  Yes If yes, check where applicable:

Sleeping too little  Sleeping too much  Poor quality sleep  Disturbing dreams

Other \_\_\_\_\_



4. What do you hope to accomplish through counseling?

5. What are some effective coping strategies that you've learned?

6. Check each of the following symptoms you are currently or have experienced within the past 6 months.

Relationship Issues:

- |                     |                          |                    |                          |                               |                          |
|---------------------|--------------------------|--------------------|--------------------------|-------------------------------|--------------------------|
| Affection           | <input type="checkbox"/> | Holding other back | <input type="checkbox"/> | Sexual Issues                 | <input type="checkbox"/> |
| Agreeing on chores  | <input type="checkbox"/> | Housing            | <input type="checkbox"/> | Showing appreciation          | <input type="checkbox"/> |
| Closeness           | <input type="checkbox"/> | Infidelity         | <input type="checkbox"/> | Solving problems together     | <input type="checkbox"/> |
| Common Goals        | <input type="checkbox"/> | In-laws            | <input type="checkbox"/> | Spouses/partner's cleanliness | <input type="checkbox"/> |
| Common interests    | <input type="checkbox"/> | Jealousy           | <input type="checkbox"/> | Trusting each other           | <input type="checkbox"/> |
| Communication       | <input type="checkbox"/> | Parenting          | <input type="checkbox"/> | Use of time                   | <input type="checkbox"/> |
| Finances            | <input type="checkbox"/> | Physical fighting  | <input type="checkbox"/> | Verbal fighting               | <input type="checkbox"/> |
| Friendships         | <input type="checkbox"/> | Recreation         | <input type="checkbox"/> | Other:                        |                          |
| Guilt / Shame       | <input type="checkbox"/> | Relatives          | <input type="checkbox"/> |                               |                          |
| Having fun together | <input type="checkbox"/> |                    |                          |                               |                          |

7. Which of these problems, issues or questions do you wish to address in counseling at this time? Why now?

8. Which of these problems are you primarily responsible for and which are the responsibility of others? Who are these other persons?

9. Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

10. From whom do you receive support and encouragement?

11. What are your biggest strengths as a couple?