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 ☐ Artemis Counseling ☐ Creative Life
☐ Insurance ☐ Facebook/Social Media ☐ Walked by
☐ Referred by: _____

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)

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

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	☐	☐	☐ Yes	☐ No
Becoming silent/withdrawing	☐	☐	☐ Yes	☐ No
Begging	☐	☐	☐ Yes	☐ No
Being mean	☐	☐	☐ Yes	☐ No
Breaking things	☐	☐	☐ Yes	☐ No
Bringing up the past	☐	☐	☐ Yes	☐ No
Criticizing	☐	☐	☐ Yes	☐ No
Cruel accusations	☐	☐	☐ Yes	☐ No
Crying	☐	☐	☐ Yes	☐ No
Leaving the house	☐	☐	☐ Yes	☐ No
Making peace	☐	☐	☐ Yes	☐ No
Moodiness	☐	☐	☐ Yes	☐ No
Name-calling	☐	☐	☐ Yes	☐ No
Not listening	☐	☐	☐ Yes	☐ No
Physical abuse	☐	☐	☐ Yes	☐ No
Physical threats	☐	☐	☐ Yes	☐ No
Sarcasm	☐	☐	☐ Yes	☐ No
Screaming	☐	☐	☐ Yes	☐ No
Slamming doors	☐	☐	☐ Yes	☐ No
Speaking irrationally	☐	☐	☐ Yes	☐ No
Speaking rationally	☐	☐	☐ Yes	☐ No
Sulking	☐	☐	☐ Yes	☐ No
Swearing	☐	☐	☐ Yes	☐ No
Threatening breaking up	☐	☐	☐ Yes	☐ No
Threatening taking the kids	☐	☐	☐ Yes	☐ No
Throwing things	☐	☐	☐ Yes	☐ No
Verbal abuse	☐	☐	☐ Yes	☐ No
Yelling	☐	☐	☐ Yes	☐ No
_____	☐	☐	☐ Yes	☐ No

7. Do you feel as though your temper adversely affects your relationship? ☐ Yes ☐ No
Your partner's temper? ☐ Yes ☐ No

8. 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? _____

12. 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

13. 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

14. ***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

16. 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

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

___ Eating disorders/body image
___ Academics or work
___ Finances
___ Outside interests (extracurricular)
___ Perfectionism
___ Technology use
___ Stress/anxiety
___ Phobias (type(s): _____)
___ Sadness/depression
___ Chronic pain/illness (type(s): _____)
___ Childhood abuse (i.e. physical, sexual, emotional)
___ Sexual assault/rape
  ___ Recently (when: _____)
  ___ In the past
___ Alcohol/problematic substance use
___ Gambling
___ Death of someone close
  ___ Recently (when: _____)
  ___ In the past
___ Other: _____

___ Culture/identity
___ Spirituality/religion
___ Dating
___ Trust
___ Sexual health
___ Coming out
___ Transitioning
___ Fertility/pregnancy
___ Parenting
___ Infidelity
___ Domestic violence/abuse
___ Family (ie. divorce, alcoholism)
___ Relationships
  ___ Family
  ___ Friend
  ___ Parent
  ___ Significant other
  ___ Roommate
  ___ Coworker

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

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

23. 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? _____

24. Have you been on any medications in the past for mental health issues? ☐ Yes ☐ No

If yes, please list: _____

25. Have you previously seen a therapist? ☐ Yes ☐ No

Who/Where? _____ How long ago? _____

For what types of issues? _____

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

27. 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: _____

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

Never 0 ***Seldom 1*** ***Often 2*** ***Always 3***

___ Difficulty concentrating
___ Crying
___ Missing work/class
___ Feeling helpless
___ Negativity
___ Feeling uptight/tense
___ Worrying
___ Feeling hopeless
___ Feeling afraid
___ Lying to others
___ Feeling out of control
___ Feelings of self-doubt
___ Injuring self
___ Loneliness
___ Nervousness around others
___ Other: _____

___ Memory loss or blackouts
___ Difficulty sleeping
___ Stealing
___ Anger
___ Jealousy
___ Eating binges
___ Drinking heavily
___ Problematic drug use
___ Feelings of guilt
___ Withdrawing socially
___ Sexual preoccupation/obsessions
___ Low sex drive
___ Suicidal thoughts
___ Physical symptoms (i.e. headaches, digestive)
List: _____
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