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 ☐ Engaged ☐ 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. 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.

6. 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

7. ***If neither you nor your partner has children, please move on to Question #8***. 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. _____	_____	_____	_____

8. Please check any topics that are ***areas of struggle within your relationship***. If not applicable, leave blank.

___ Alcohol/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
___ Personality differences
___ Physical attraction
___ Fertility/Pregnancy
___ Sex life
___ Social life
___ Spirituality/religion
___ Technology use
___ Time together
___ Trust
___ Violence
___ Withdrawing
___ Working too much

9. Please check any behaviors that are present when you ***argue or engage in conflict***. If not applicable, leave blank.

___ Becoming silent
___ Begging
___ Being mean
___ Breaking things
___ Bringing up the past
___ Criticizing
___ Cruel accusations
___ Crying
___ Leaving the home
___ Moodiness
___ Name-calling
___ Not apologizing
___ Not making peace
___ Not listening
___ Not speaking rationally
___ Physical threats
___ Sarcasm
___ Screaming
___ Slamming doors
___ Sulking
___ Swearing
___ Threatening breaking up
___ Threatening taking the kids
___ Throwing things
___ Withdrawing
___ Yelling

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

11. 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

15. 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

16. 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

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

_____

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

19. 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? _____

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

If yes, please list: _____

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

Who/Where? _____ How long ago? _____
For what types of issues? _____

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

23. 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: _____

24. Please rate the following symptoms by their experienced frequency 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. ***You do not have to complete this section if you have already provided us with your insurance information.*** 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