Couple Intake Form

Demographics

Partner 1:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Partner 2:

Name: _____ Date: _____

Address: ☐ Same as above _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Referred by: _____

☐ Therapist ☐ Church ☐ Physician ☐ Agency ☐ Friend ☐ Internet

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Marital Status: Dating Engaged Married (___years married) Separated Divorced (circle one)

Children: Name Age

_____ _____

_____ _____

_____ _____

_____ _____

*If children are stepsiblings or partial siblings please indicate next to their name

Mental Health

Has anyone in the immediate family currently or historically been suicidal? ☐ Yes ☐ No

If yes, who and when?_____

Has anyone in the immediate family been hospitalized for mental health related issues? ☐ Yes ☐ No

If yes, who and when?_____

Is anyone in the immediate family currently receiving counseling services with another professional?

☐ Yes ☐ No If yes, who and for how long?_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? ☐ Yes ☐ No

Who, how often, and what substances are used? _____

Has anyone in the family ever struck, physically restrained, used violence against, or injured any person within the family? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Reasons for Seeking Couples Counseling:

_____

_____

How would you know that your time in therapy has been successful? What would look different in your relationship? _____

_____

Have either of you considered separation or divorce as a result of current marital problems? ☐ Yes ☐ No

If yes, when? _____

Have you had any previous couples counseling? ☐ Yes ☐ No

Name of therapist: _____ Date of counseling: _____

Would you be willing to sign a release of information to talk with previous counselor? ☐ Yes ☐ No

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Reflections
COUNSELING
GROUP

Partner Inventory

Partner 1: (name) _____

List some strengths of your relationship: _____

_____

List some weaknesses of your relationship: _____

_____

Indicate anything that pertains to you presently:

Anger
Education concerns
Sexual problems
Work problems
Drug use
Loneliness
Relationship problems
Fatigue
Lack of ambition
Stomach problems
Financial concerns
Concerns about appearance
Suicidal thoughts
Fears about the future
Problems with friends
Problems concentrating
Nightmares
Quick temper
Concerns about my thoughts
Concerns about parenthood
Health problems
Concerns about age
Nervousness
Unable to relax
Concerns about making decisions
Stress

Problems with self-esteem
Concerns about sexual orientation
Concerns about sexual desire
Concerns about sexual satisfaction
Physical abuse
Anxiety
Marital separation
Lack of energy
Feelings of inferiority
Lack of appetite
Sexual abuse
Concerns about children
Concerns about career choices
Concerns about weight
Shyness
Legal problems
Problems with self-control
Memory difficulty
Lack of sleep
Under/Over-eating
Problems with alcohol use
Unhappiness
Depression
Headaches
Fear
Other: _____

Indicate anything that has happened to you in the past three years:

Death of a spouse/partner

Death of another family member

Relationship Problems

Changes in relationship status

Family Problems (children, in-laws)

Loss of Job

Move to another city or state

Major illness or injury–family member

Legal Problems

Financial Problems

Other: _____

Additional Contributing Factors:

Reflections COUNSELING GROUP

Partner Inventory

Partner 2: (name) _____

List some strengths of your relationship: _____

_____

List some weaknesses of your relationship: _____

_____

Indicate anything that pertains to you presently:

Anger
Education concerns
Sexual problems
Work problems
Drug use
Loneliness
Relationship problems
Fatigue
Lack of ambition
Stomach problems
Financial concerns
Concerns about appearance
Suicidal thoughts
Fears about the future
Problems with friends
Problems concentrating
Nightmares
Quick temper
Concerns about my thoughts
Concerns about parenthood
Health problems
Concerns about age
Nervousness
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Unhappiness
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Other: _____

Indicate anything that has happened to you in the past three years:

Death of a spouse/partner

Death of another family member

Relationship Problems

Changes in relationship status

Family Problems (children, in-laws)

Loss of Job

Move to another city or state

Major illness or injury–yourself

Major illness or injury–family member

Legal Problems

Financial Problems

Other: _____

Additional Contributing Factors: