



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: _____ Race: _____

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: _____ Race: _____

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: _____

Partner Inventory

Partner 1: (name) _____

List some strengths of your relationship: _____

List some weaknesses of your relationship: _____

Indicate anything that pertains to you presently:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Concerns about my thoughts | <input type="checkbox"/> Feelings of inferiority |
| <input type="checkbox"/> Education concerns | <input type="checkbox"/> Concerns about parenthood | <input type="checkbox"/> Lack of appetite |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Health problems | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Work problems | <input type="checkbox"/> Concerns about age | <input type="checkbox"/> Concerns about children |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Concerns about career choices |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Concerns about weight |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Concerns about making decisions | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Lack of ambition | <input type="checkbox"/> Problems with self-esteem | <input type="checkbox"/> Problems with self-control |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Concerns about sexual orientation | <input type="checkbox"/> Memory difficulty |
| <input type="checkbox"/> Financial concerns | <input type="checkbox"/> Concerns about sexual desire | <input type="checkbox"/> Lack of sleep |
| <input type="checkbox"/> Concerns about appearance | <input type="checkbox"/> Concerns about sexual satisfaction | <input type="checkbox"/> Under/Over-eating |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Problems with alcohol use |
| <input type="checkbox"/> Fears about the future | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Unhappiness |
| <input type="checkbox"/> Problems with friends | <input type="checkbox"/> Marital separation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Problems concentrating | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nightmares | | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Quick temper | | <input type="checkbox"/> Other: _____ |

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

- | | |
|--|--|
| <input type="checkbox"/> Death of a spouse/partner | <input type="checkbox"/> Move to another city or state |
| <input type="checkbox"/> Death of another family member | <input type="checkbox"/> Major illness or injury—yourself |
| <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Major illness or injury—family member |
| <input type="checkbox"/> Changes in relationship status | <input type="checkbox"/> Legal Problems |
| <input type="checkbox"/> Family Problems (children, in-laws) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Loss of Job | |
| <input type="checkbox"/> Financial Problems | |

Partner Inventory

Partner 2: (name) _____

List some strengths of your relationship: _____

List some weaknesses of your relationship: _____

Indicate anything that pertains to you presently:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Concerns about my thoughts | <input type="checkbox"/> Feelings of inferiority |
| <input type="checkbox"/> Education concerns | <input type="checkbox"/> Concerns about parenthood | <input type="checkbox"/> Lack of appetite |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Health problems | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Work problems | <input type="checkbox"/> Concerns about age | <input type="checkbox"/> Concerns about children |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Concerns about career choices |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Concerns about weight |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Concerns about making decisions | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Lack of ambition | <input type="checkbox"/> Problems with self-esteem | <input type="checkbox"/> Problems with self-control |
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