# Initial Intake for Couple's Therapy

Date call received: _____/_____/_____
Date intake completed: _____/_____/_____
Date no case made: _____/_____/_____

Returning client(s)? Yes___ No ___

Date services began: _____/_____/_____

Name | Age | Birthdate | Gender (F/M/T)

Street | City | Zip | County

Telephone number(s) | Email address(es)

Whom to contact in case of emergency/phone turned off, etc. | Phone

Is it safe to leave a message? Y N | If no, indicate reason on line above.

Best days & times for appointment | Best times to contact | Best way to contact

***How do you define your race/ethnicity***?

- ☐ Black/African American
- ☐ Latino/Hispanic
- ☐ Native American/First Peoples
- ☐ White/European American
- ☐ Multi-ethnic
- ☐ Asian/Pacific Islander
- ☐ Refused
- ☐ Other

Do you have children/stepchildren? Y N If yes, sex and age of each child:

Do your children live with you? Y N If no, with whom/where:

Do you consider yourself "head of household?" Y N

***What is your educational background?*** ***Are you a student now?*** ***Y N*** ***Full-time _____ Part-time _____***

- ☐ None
- ☐ Some college
- ☐ Graduate or professional degree
- ☐ Elementary school
- ☐ College degree
- ☐ GED
- ☐ High school
- ☐ Technical school
- ☐ Other

**What is your job status?**

☐ Employed full-time ☐ Unemployed ☐ Temporarily unemployed

☐ Employed part-time ☐ Retired ☐ A homemaker (not working outside the home)

Relationship Status: ___ Partnered ___ Engaged ___ Domestic Partners ___ Married (not separated) ___ Separated

___ Divorcing ___ Divorced ___ Living together ___ Dating

Length of current relationship? _____

Length of any previous relationship? _____

Do you share your income(s) with each other or with someone else? Y N

Number of people supported by your household income?

Number of people living in your household?

Please circle the description of the degree of your happiness with your marriage.

| | | | | | | |
|---|---|---|---|---|---|---|
| EXTREMELY UNHAPPY | FAIRLY UNHAPPY | A LITTLE UNHAPPY | HAPPY | VERY HAPPY | EXTREMELY HAPPY | PERFECT |

In your own words, what do you see as the major problems in your marriage at this time?

Would you mind sharing with me some of the reasons you're looking for couples counseling at this time?

List one thing that you feel you could to improve the marriage regardless of what your partner does or says.

What do you see as your biggest strengths as a couple?

What do you see as your biggest weaknesses as a couple?

| | |
|---|---|
| Have you ever been to counseling as a result of problems in this relationship prior to today? | [ YES ] [ NO ] |
| • Do you consider the counseling to have been helpful? | [ YES ] [ NO ] |
| Have you ever been in individual counseling before? | [ YES ] [ NO ] |
| • Do you consider the individual counseling to have been successful? | [ YES ] [ NO ] |
| Do either you consume alcohol or drugs to the point of intoxication? | [ YES ] [ NO ] |
| Do you want to participate in counseling to improve your marriage now? | [ YES ] [ NO ] |
| Has your partner ever struck, physically restrained, used violence against, or injured you within the last 3 years? | [ YES ] [ NO ] |
| Have either you or your partner threatened marital divorce or separation as a result of your current problems? | [ YES ] [ NO ] |
| • Which one | [ ME ] [ THEM ] |
| Have you or your partner ever threatened divorce or separation for other problems prior to the one you are seeking counseling for now? | [ YES ] [ NO ] |
| • Which one? | [ ME ] [ THEM ] |
| Do you perceive that either you or your partner has withdrawn emotionally from the marriage? | [ YES ] [ NO ] |
| • Which one of you | [ ME ] [ THEM ] |
| How frequently have you had sexual relations in the last month (write number to the right) | |

How enjoyable is your sexual relationship? (circle the best response)

| | | | | |
|---|---|---|---|---|
| TERRIBLE | MORE UNPLEASANT THAN PLEASANT | NOT PLEASANT NOT UNPLEASANT | MORE PLEASANT THAN UNPLEASANT | GREAT |

How satisfied are you with your sexual relations? (circle the best response)

| | | | | |
|---|---|---|---|---|
| WAY TOO OFTEN FOR ME | A BIT TOO OFTEN | ABOUT RIGHT | A BIT TO SELDOM | WAY TO SELDOM FOR ME |

What is your current level of stress?

| | | | | | | |
|---|---|---|---|---|---|---|
| EXTREMELY HIGH | VERY HIGH | HIGH | MODERATE | LOW | VERY LOW | EXTREMELY LOW |

| To what degree do you have family or friends that support you as a couple? (circle one) | | | | | | |
|---|---|---|---|---|---|---|
| EXTREMELY SUPPORTIVE | VERY SUPPORTIVE | HIGH | MODERATE | LOW | VERY LOW SUPPORT | EXTREMELY LOW SUPPORT |
| To what degree do you and your partner share a similar world view and values? (circle one) | | | | | | |
| EXTREMELY HIGH | VERY HIGH | HIGH | MODERATE | LOW | VERY LOW | EXTREMELY LOW |
| To what degree do are you committed to see your relationship succeed and be more satisfying? (circle one) | | | | | | |
| EXTREMELY HIGH | VERY HIGH | HIGH | MODERATE | LOW | VERY LOW | EXTREMELY LOW |

In your own words, what would it take for you to feel this counseling has been successful?

*Are you experiencing any of the following?*

- ☐ Anger
- ☐ Anxiety
- ☐ Bi-polar/mood swings
- ☐ Chemical dependency
- ☐ Childhood issues
- ☐ Chronic illness
- ☐ Depression
- ☐ Disability issues
- ☐ Disordered eating
- ☐ Divorce
- ☐ Abuse/violence
- ☐ Financial stress
- ☐ Grief and loss
- ☐ Identity issues
- ☐ Legal challenges
- ☐ Parenting role
- ☐ Partner relationship
- ☐ Self-esteem
- ☐ Sexual assault
- ☐ Suicidality

***Additional notes:***

***Medications?***

Have you ever been hospitalized for emotional/psychological problems, and if so, when? Y N
Have you made any suicide attempts, and if so, when? Y N

Are you feeling suicidal now? Y N If *yes,* assess for plan, method, means, access, level of premeditation. Circle referrals and specify safety plan.

# Family History/Genogram*

*****T*o be completed with your counselor during the session*