

Couples' Counseling Intake Form

Date: _____

Name: _____

Spouse/Partner's Name: _____

Address: _____

Telephone- Home: _____ Cell Phones: _____

E-mails: _____

Relationship Status
(check all that apply)

- Married
- Separated
- Divorced
- Dating
- Cohabiting
- Living together
- Living apart

Current Employment

- Full-time
- Part-time
- Homemaker
- Unemployed
- Full-time student
- Part-time student
- Retired

Annual Household Income

- \$0-9999
- \$10,000-24,999
- \$25,000-49,000
- \$50,000-74,999
- \$75,000+

Length of time in current relationship: _____

Children (including, biological, adopted, foster, step):

Name	Sex	Age	Type	Custody
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check any of the reasons listed below that resulted in your request for counseling:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Depression or anxiety <input type="checkbox"/> Alcohol/drug abuse <input type="checkbox"/> Marital problems <input type="checkbox"/> Communication difficulties <input type="checkbox"/> Psychological evaluation <input type="checkbox"/> Improve sexual relations <input type="checkbox"/> Child/parent conflict <input type="checkbox"/> Divorce counseling <input type="checkbox"/> Sexual orientation questions | <ul style="list-style-type: none"> <input type="checkbox"/> Thinking of harming self or others <input type="checkbox"/> Learning difficulties <input type="checkbox"/> School problems <input type="checkbox"/> Family counseling <input type="checkbox"/> Individual counseling <input type="checkbox"/> Difficulty with loss or death <input type="checkbox"/> Relationship enhancement <input type="checkbox"/> Abuse (physical/mental) <input type="checkbox"/> Pre-marital counseling |
|---|---|

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As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern

- No concern
- Little concern
- Moderate concern
- Serious concern
- Very serious concern

Frequency

- No occurrence
- Occurs rarely
- Occurs sometimes
- Occurs frequently
- Occurs nearly always

What do you hope to accomplish through counseling?

What have you already done to deal with the difficulties?

What are your biggest strengths as a couple?

Have you received prior counseling related to any of the above problems? Yes No

If yes, was it: Outpatient Inpatient

When: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

Outcome: Very successful Somewhat successful Stayed the same

Somewhat worse Much worse

Were you referred to this agency? Yes No If yes, by whom? _____

Signature: _____ Date: _____

Signature: _____ Date: _____