Daly Counseling & Consulting, PLLC

www.dalycounseling.com

COUPLES INTAKE FORM

Please complete all information requested on this form, it is important for your care.

Each *person needs to complete their own "Couples Intake Form."*

Allow 45-60 minutes each to complete.

Date: _____

Name:_____

*How did you hear about us?*_____

Main Phone:_____ May we leave a message? check one: □ YES □ NO

Alt. Phone:_____ May we leave a message? check one: □ YES □ NO

Email:_____@_____

Address:_____
(street, city, zip)

Date of Birth:_____ Age:_____ Gender (check one): □ Male □ Female

Present Marital Status (check one): □ NEVER MARRIED □ ENGAGED □ MARRIED □ WIDOWED □ DIVORCED □ DIVORCED & REMARRIED □ WIDOWED & REMARRIED #OF MARRIAGES:____

Occupation:_____ Place of Employment:_____

Name of Partner:_____
Relationship Status: (check all that apply)

□ Married □ Separated □ Divorced □ Dating □ Cohabitating. □ Living together □ Living apart

Length of time in current relationship: _____

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? (check the box for each below)*

Concern	***Frequency***
□ No concern	□ No occurrence
□ Little concern	□ Occurs rarely
□ Moderate concern	□ Occurs sometimes
□ Serious concern	□ Occurs frequently
□ Very serious concern	□ 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?

_____

_____

_____

On a scale of 1 to 10, rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship (1= extremely unhappy 10= extremely happy)?

Explain the rating you give yourself.

_____

_____

_____

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

_____

_____

_____

Have you received prior couples counseling related to any of the above problems? □ Yes □ No
If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

What was the outcome (check one)?
□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in individual counseling before? □ Yes □ No If so, give a brief summary of concerns that you addressed.

_____

_____

_____

Are you presently having suicidal thoughts (now or last 4 weeks)? □ YES □ NO

If Yes, please describe:_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

If yes for either, who, how often and what drugs or alcohol?

_____

_____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

If yes for either, who, how often and what happened.

_____

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? _____times

On a scale of 1 to 10, rate how enjoyable your sexual relationship is (1= extremely unpleasant 10= extremely pleasant)? Explain the rating you give yourself.

_____

_____

_____

On a scale of 1 to 10, rate how satisfied are you with the frequency of your sexual relations (1= extremely unsatisfied 10= extremely satisfied)? Explain the rating you give yourself.

_____

_____

_____

On a scale of 1 to 10, rate your current level of **overall** stress (1= no stress 10= high stress)? Explain the rating you give yourself.

_____

_____

_____

On a scale of 1 to 10, rate your current level of stress **in the relationship** (1= no stress 10= high stress)? Explain the rating you give yourself.

_____

_____

_____

Rank order the top three concerns that you have in your relationship with your partner (1 being the most problematic):

1. _____

2. _____

3. _____

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note pivotal/significant events in your relationship (e.g., one of you moved out, one of you cheated).

Complete satisfaction

No satisfaction

When you met/began dating **Relationship over time** *Current*

Anything else you would like your counselor to know:_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.

Office Use Only

Notes:

Reviewed by:_____ _____

Printed Name & Signature Date