HOPE Counseling Center
Healthy **O**utcomes for **P**ersonal **E**nrichment
All Counselors are supervised by a licensed Marriage and Family Therapist

Couples Intake Form

each individual to complete

Date:_____ Client: _____

Therapist:_____

What are the issues that led you to decide to come to couples therapy? _____

How long have you been together?_____Years_____Months _____

What initially attracted you to your partner? _____

What was the beginning of your relationship like and how long did this phase last? _____

What are some of the strengths you bring to the relationship? _____

What do you enjoy about your relationship? _____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

What do you do when there is conflict between the two of you? What does your partner do? _____

What strengths and weaknesses do you have in resolving conflict? What would you say are your partner's strengths and weaknesses in resolving conflict?

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

If yes, who? ____Me ___Partner ____Both

Do you perceive that either you or your partner has withdrawn from the relationship?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

If yes, who? ___Me ___Partner ___Both

Describe your sexual relationship. What do you find most satisfying about it? What don't you like about it? How has your sexual relationship changed since you were first together?

What is your current level of stress (in the relationship)?

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress (overall)?

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

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

1._____

2._____

3._____

Have you received prior couples counseling related to any of the above concerns? ___Yes ___No

If yes, when: _____ Length of treatment: _____

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
Is so, give a brief summary of concerns that you addressed:

What is your relationship like with your family growing up? _____

Are any of the following concerns for yourself or your partner? Please feel free to explain items you feel are important.

Alcohol/drugs (type?) _____

Pornography (type?)_____

Domestic violence (past or present)_____

Does anyone in your family have any know mental health diagnoses? ____Yes ____No
If yes, please describe who and their diagnosis:

Do you have any mental health diagnoses? ___ Yes ___ No
If yes, please describe: _____

Any past suicidal ideation or attempts?_____Whom?_____
When?_____Outcome? _____

Present suicidal ideation? _____Yes ___No If yes, please elaborate _____

Do you have a medical provider? ____Yes ____No
If yes, what is his or her name? _____

Do you have any medical issues? ____Yes ____No
If yes, please describe: _____
_____

Please list any medications you are currently taking, or have taken during the past 6 months. (Include prescribed and over the counter medications)

Medication	Dosage	Used for	Prescribing Doctor

Has there been any verbal, emotional, physical, or sexual abuse that has happened to you?
____Yes ____No
If yes, was the assailant someone you knew? ____Yes ____No
When did this happen? _____
Where is this person now? _____

Have you ever had any legal issues? ____Yes _____No
If yes, please describe: _____
_____
_____

Do you have children? ____Yes ___No Do they presently live with you? ____Yes ___No

Ages? _____ _____ _____ _____

Any other information you think is important for me to know? _____