Intake Questionnaire for Couples Counseling

** indicates a required field*

Prior to your first appointment, please answer all questions below. Do not spend too much time on any question.

*** Name of partner:**

*** Relationship status (check all that apply):**

- [ ] Married
- [ ] Separated
- [ ] Divorced
- [ ] Dating
- [ ] Cohabitating/living together
- [ ] Living apart

*** Length of time in current relationship:**

*** What do you hope to accomplish through counseling?**

*** As you think about the primary reason that brings you here, how frequently does it occur?**

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

*** As you think about the primary reason that brings you here, how would you rate your overall concern about it?**

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

*** What have you already done to deal with the difficulties?**

*** Please rate your current level of relationship happiness by selecting the number that corresponds with your current feelings about the relationship:**

- ○ 1 = Extremely unhappy
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

- 8
- 9
- 10 = Extremely happy

*** Have you received prior couples counseling related to any of the above problems?**

- Yes
- No

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

*** Describe any prior experiences you have had with couples counseling, including when, where, length of treatment, who counseled you, and the problems that were treated, and the outcome. Please be detailed. (If you have not received prior couples counseling, please type N/A.)**

*** Have either you or your partner been in individual counseling before?**

- Yes
- No

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

- ○ Yes
- ○ No

*** If married, has either of you threatened to separate or divorce as a result of the current relationship problems? If not married, please answer N/A.**

- ○ Yes
- ○ No
- ○ N/A

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

- ○ Yes
- ○ No

*** Do you perceive that either you or your partner has withdrawn from the relationship?**

- ○ Yes
- ○ No

*** If married, have either you or your partner consulted with a lawyer about divorce? If not married, please answer N/A.**

- ○ Yes
- ○ No
- ○ N/A

*** What is your current level of stress (overall)?**

- ○ 1 = No stress

- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 = High stress

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

- 1 = no stress
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 = high stress

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

*** What are your biggest strengths as a couple?**

Thank you for completing this. Please note that you will be asked to talk about your answers in appointments.