Couples Therapy Initial Intake Form

Please complete this questionnaire to the best of your abilities and comfortability and bring it with you to your first appointment. Please note that I'll collect these forms from you and your partner, and throughout your treatment these topics will be explored when appropriate; however, your partner will not be shown this form.

Client's Name:	Date:
Name of Partner:	
Relationship Status: (check all that apply)	Cohabitating
Separated Divorced Dating	Living in the same household Living apart
Length of time in current relationship:	
What is the challenge or challenges that led	you to decide to come to couples therapy?

How would you rate its frequency and your overall level of concern at this point in time?

Concern	Frequency
No concern	No occurrence
Little concern	Occurs rarely
Moderate concern	Occurs sometimes
Serious concern	Occurs frequently
Very serious concern	Occurs nearly always

Rank the order of the top three concerns that you have in your relationship with your partner, if different from above (1 being the most problematic):

1.	
2.	
3.	
0.	

What do you hope to accomplish through couples therapy?

What have you already done to deal with the difficulties?

What are you biggest strengths as a couple?

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 unhap	ру									extremely happy

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?	Yes No
If yes, when:	Where:
By whom:	Length of treatment:

Challenges addressed:

What was the outcome? (check one please)

- ___ Very successful
- ___ Somewhat successful
- ___ Stayed the same
- ___ Somewhat worse
- ___ Much worse

Do either you or your partner drink alcohol or take drugs? ___ Yes ___ No If yes for either, who, how often and what drugs and/or alcohol?

Have either you or your partner struck, physically re	estrained, used violence against or injured
the other person? Yes No	
If yes for either, who, how often and what happened	

Has either of you threatened to	o separate or divorce (if married) as a result of the current rela-
tionship problems? Yes	No
If yes, who? Me Partner	Both of us

If married,	have eitl	her you or	your partner	consulted	with a lawyer	about divorce?
If yes, who?	? Me _	Partner	Both of us			

Do you perce	eive tha	t either you	ı or your partne	er has withdrawn from	the relationship?
If yes, who? _	Me	_ Partner _	Both of us		

How enjoyable is your sexual relationship? (circle one please)

1	2	3	4	5	6	7	8	9	10
extremely unpleas	ant								extremely pleasant

1	2	3	4	5	6	7	8	9	10
extremely unsatisfie	ed								extremely satisfied

Advance, A Licensed Clinical Social Worker Corporation											
How satisfied are you with quality of your sexual relations? (circle one please)											
1 extremely unsatisfied	2	3	4	5	6	7	8	9	10 extremely satisfied		
What is your current level of stress (overall)? (circle one please)											
1 no stress	2	3	4	5	6	7	8	9	10 high stress		
What is your current level of stress (in the relationship)? (circle one please)											
1 no stress	2	3	4	5	6	7	8	9	10 high stress		

Katya Kosarenko, LCSW 24870, owner

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How are the two of you similar and how you are different?

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

How open are you in expressing your innermost feelings, desires and thoughts to your partner? Please explain the rating you give yourself.

1	2	3	4	5	6	7	8	9	10
totally closed									totally open

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)

No satisfaction

When you met/began dating

RELATIONSHIP OVER TIME

Current