



Couples Intake Questionnaire

Name: _____ Date _____

Phone: _____ May I leave a message? Y N

Is it acceptable to email you? If so, email address: _____

Relationship Status: (check all that apply)

- | | | |
|-----------|-----------------|----------|
| Married | Living Together | Divorced |
| Separated | Living apart | Dating |

What is your major and/or program enrolled in at UIW?

What is the problem that led you to decide to come to couples therapy?

What do you hope to accomplish through counseling? (check all that apply):

- | | | |
|----------------------------|----------------------------|------------------------------|
| Improve communication | Conflict resolution | Parenting skills |
| Problem solving | More intimacy (emotional) | More intimacy (sexual) |
| More quality time together | Resolve individual issues | More autonomy |
| More respect/understanding | Power and control issues | More hobbies |
| More social contacts | More sharing of the chores | Help for children's behavior |
- Other (specify): _____

What have you already done to deal with the difficulties?

What are your biggest strengths as a couple?

Please rate your current level of relationship happiness by checking 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)

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, With whom: _____

Where: _____ Length of treatment _____

Outcome: _____

Have either of you been in individual counseling before? Yes No

If so, give a brief summary of concerns you addressed.

Do either you or your partner drink alcohol or take drugs to intoxication? Yes No

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

Do you ever wish your partner would cut back on his/her drinking or drug use?

Yes No N/A

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

Yes No If yes, 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?

Yes No If yes, who? Me Partner Both of us

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

Yes No If yes, who? Me Partner Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

Yes No If yes, who? Me Partner Both of us

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

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

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

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

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

1. _____
2. _____
3. _____