

COUPLES THERAPY INTAKE FORM

**If you run out of space when answering any questions, please use the back of this sheet or add a new sheet.*

DATE: _____

NAME: _____

PARTNER'S NAME: _____

Please describe your main complaints that brought you to couple therapy.

What do you hope to accomplish through psychotherapy?

What have you already done to deal with difficulties?

How long have you and your partner been together? (e.g., dating, living together, married)

What initially attracted you to your partner?

If there were any significant events that you feel relevant to the development of current conflicts, what would they be?

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 about your partner's strengths and weaknesses in resolving conflict?

Please rate your current level of relationship difficulties by circling the number that corresponds with your current feelings about the relationships (0 being not at all; and 10 being extremely difficult):

0 1 2 3 4 5 6 7 8 9 10

What is the area or topic that it is most difficult for you to open with your partner about? Why?

When do you feel most content in your relationship? When do you feel most unhappy or frustrated?

Have you received prior couples therapy? Yes No

If yes, please detail when, where, how long, for what issues, and by whom.

Have you been in individual psychotherapy before? Yes No

If yes, please detail when, where, how long, for what issues, and by whom.

Are you currently using any substances (e.g., alcohol, prescribed and/or illicit drugs) to intoxication?

Yes No If yes, please detail kinds of substances, amount, and how often.

Have you and your partner stuck, physically restrained, used violence or aggression against or injured the other person? Yes No

If yes, please detail incidents including the number of occurrence, date, and what happened.

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

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

Do you feel that either you or your partner has withdrawn from the relationship? Yes No

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

Please rate the level of your commitment to your relationship.

0 1 2 3 4 5 6 7 8 9 10

Please rate the level of your feelings of security in your relationship.

0 1 2 3 4 5 6 7 8 9 10

Please rate the level of your closeness or intimacy toward your partner.

0 1 2 3 4 5 6 7 8 9 10

Please rate the level of your perceived closeness or intimacy from your partner.

0 1 2 3 4 5 6 7 8 9 10

Please rate the level of trust in your relationship.

0 1 2 3 4 5 6 7 8 9 10

How open are you in expressing your innermost feelings, desires, and thoughts to your partner?

(0= totally closed, 10=totally open)

0 1 2 3 4 5 6 7 8 9 10

How often do you engage in sexual relations with your partner?

How enjoyable is your sexual relationship? (0= not at all, 10= extremely)

0 1 2 3 4 5 6 7 8 9 10

How satisfied are you with the frequency of your sexual relations? (0= not at all, 10= extremely)

0 1 2 3 4 5 6 7 8 9 10

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Not pivotal/significant events in your relationship (e.g., one of you moved out, one of you cheated etc.)

