COUPLES INTAKE ASSESSMENT & CLIENT INFORMATION

Demographic Information

*(***Each partner to complete their own assessment***)*

Name: _____ Date: _____

DOB: _____ Age: _____ Gender: _____

Sexuality: _____ Race: _____ Ethnicity: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail? *YES* *NO*

Is it ok to send you something in the mail? *YES* *NO*

Email: _____

Would you like to receive email communication? *YES* *NO*

How were you introduced to us? _____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your relationship right now?

1. _____
2. _____
3. _____

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What do you think those that care about you would say their concern(s) is/are?

What solutions have you tried to resolve the problems that you are seeking therapy for?

Change is Coming…

What are your expectations from therapy? the therapist?

Looking into the future how will you know that our work and time together has been worth it? List concrete changes you will see:

What other things would you like to see change in your life (family, career, health, etc.)

What are your ***partner's*** worries, stresses, hopes, dreams and aspirations?

If you could do anything in the world without concern of time, resources, money, what would you be wildly passionate about doing?

What do you currently do for work?

Who/what would you say your support system is (people, religious, spiritual, affiliations…)?

List 5 strengths about yourself and relationship, give examples of each:

1.
2.
3.

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4. _____
5. _____

Any current or past medical issues, hospitalizations, accidents, injuries, allergies, illnesses, or surgeries that impact you currently? If yes, what?

_____
_____

List any medications (OTC & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and reasons:

_____
_____

In the past year have there been any changes in your life – moves, appetite, sleep, health, family, overall functioning.

_____
_____

Important Questions We Must Ask

Have you ever thought about killing yourself or not wanting to be alive? YES NO
If yes, please explain:

_____
_____

Have you ever planned to kill yourself? YES NO
If yes, please explain:

_____
_____

Have you ever attempted to kill yourself? YES NO
If yes, please explain:

_____
_____

Have you ever felt like you wanted to seriously hurt or kill someone else? YES NO
If yes, please explain:

_____
_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____
_____

Is there any history past or present of abuse or violence? YES NO
If so, please explain:

_____

_____

Are you currently using any illegal drugs or is the reason you are seeking therapy services substance related? *If you answered yes to this question, please complete the substance use portion of the intake as well. _____

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain:

_____

_____

Intimate Relationship

How long have you been together? Married? _____

What do you do together as a couple? How do you connect on a daily basis (dinner, texts…)

_____

_____

What do you do/enjoy individually? What do you hope and/or aspire to?

_____

_____

Describe your communication, emotional intimacy, and connection in your relationship:

_____

Describe sex in your relationship: satisfaction level, frequency, how sex affects your relationship, etc:

_____

_____

Most couples think betrayals are affairs, but betrayals come in many forms in relationships. Has there been any major betrayals in your relationship that has had a **major** affect on you such as: constant lying, broken promises, affairs, coldness/distance/absenteeism, forming coalitions (between you and another person or between your partner and another person), withdrawal of sexual interest, disrespect, unfairness, and selfishness. If so please describe:

_____

_____

Answer the following regarding your relationship:

1. Like _____
2. Dislike _____
3. Not enough of _____
4. Too much of _____
5. Ideal relationship _____

Check off the areas in your relationship that you do well in or **don't** want to change:

☐Financial Value/Beliefs/Philosophies
☐Romance
☐Friendship
☐Emotional Intimacy/Connection
☐Shared Goals
☐Fun
☐Feeling Loved & Valued
☐Communication
☐Sex
☐Parenting Value/Beliefs/Philosophies
☐Trust
☐Support
☐Dealing with Conflict
☐Other: _____

Check off the areas in your relationship that you would like to change:

☐Financial Value/Beliefs/Philosophies
☐Romance
☐Friendship
☐Emotional Intimacy/Connection
☐Shared Goals
☐Fun
☐Feeling Loved & Valued
☐Communication
☐Sex
☐Parenting Value/Beliefs/Philosophies
☐Trust
☐Support
☐Dealing with Conflict
☐Other: _____

Understanding Your Family & Influences

** Space left for therapist to draw genogram (family tree):*

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How would you describe your upbringing? And how does it impact your relationship?

_____

_____

Describe your relationship with the following:

Mother: _____

Father: _____

Siblings: Age, Name and Sex:

a. Sibling 1 _____
b. Sibling 2 _____
c. Sibling 3 _____

Children: Age, Name and Sex:

a. Child 1 _____
b. Child 2 _____
c. Child 3 _____
d. Child 4 _____

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

_____

_____

_____

_____

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