paulelmore
1800 Blankenship Rd. Suite 200
West Linn, OR 97068
(503) 863-4074

Date _____

Couples Intake Form

Personal Information

Name: _____ Age: _____

Partner's Name: _____

Relationship Evaluation

Relationship Status

Please check ALL that apply

- O Married
- O Separated
- O Divorced
- O Dating
- O Cohabitating
- O Living Together
- O Living Apart

Length of time in CURRENT relationship? _____

Issues

As you think about your current relationship, how would you rate it's frequency and your overall level of concerning?

CONCERN

- O No Concern
- O Little Concern
- O Moderate Concern
- O Serious Concern
- O Very Serious Concern

FREQUENCY

- O No Occurrence
- O Occurs Rarely
- O Occurs Sometimes
- O Occurs Frequently
- O Occurs Nearly Always

Primary Issues

What is the primary issue you're seeking help for? _____

What do you hope to accomplish through counseling? _____

What steps have you already taken to deal with the difficulties? _____

Overall Satisfaction

Please rate your overall satisfaction with the relationship.

1	2	3	4	5	6	7	8	9	10
Extremely Dissatisfied									Extremely Satisfied

Counseling History

Couples Counseling History

Have you receive prior couples counseling related to the above issues? O Yes O No

If YES, the previous counseling experiences was: O Positive O Negative O Uncertain

Most Recent Counselor

Name: _____ Dates: _____

Agency: _____ Phone: _____

Diagnosis/Evaluation: _____

Why did you stop? _____

Personal Counseling History

Have you received personal counseling in the past? O Yes O No

If YES, the previous counseling experience was: O Positive O Negative O Uncertain

Most Recent Counselor

Name: _____ Dates: _____

Agency: _____ Phone: _____

Diagnosis/Evaluation: _____

Why did you stop? _____

Partner Counseling History

To your knowledge, has your partner ever received personal counseling? O Yes O No

Were you part of that counseling process? O Yes O No

Safety Information

Physical Safety

Have you every done any of the following to your partner?

O Verbally yelled or screamed
O Physically restrain or limit movement
O Injured the other person
O Initiated unwanted sexual contact
O Hit or slapped
O Punched
O Kicked

Has your partner ever done any of the following to you?

O Verbally yelled or screamed
O Physically restrain or limit movement
O Injured the other person
O Received unwanted sexual contact
O Hit or slapped
O Punched
O Kicked

Emotional Safety

Have either one of you threatened divorce (if married)? O Yes O No

If YES, whom? O Me O My Partner O Both

Relationship Investment

Do you perceive that either you or your partner has emotionally or relationally withdrawn from the relationship? ○ Yes ○ No

If YES, whom? ○ Me ○ My Partner ○ Both

Sexual Relationship

How frequently have you been sexually intimate with your partner in the last month? _____ Times

How enjoyable is your sexual relationship overall?

1	2	3	4	5	6	7	8	9	10
Extremely Dissatisfied									Extremely Satisfied

Are there any sexual issues you'd like to discuss in the counseling process? ○ Yes ○ No

Spirituality Practices (Optional)

Was faith, spirituality, or religion part of your childhood? ○ Yes ○ No

What faith system were you raised in? _____

What faith system do you ascribe to now? _____

Are matters of faith or spiritual practice a source of conflict in your current relationship? ○ Yes ○ No

Do you want issues of faith to be integrated into your counseling experience? ○ Yes ○ No