Couples Counseling Initial Intake Form

Agape Counseling Associates, Inc.
3806 Peachtree Ave. suite 210
Wilmington, NC 28403
910-251-7789

Name:_____ **Date:**_____

Address:_____

Phone (cell):_____

Date of Birth:_____

***Name of Partner*:**_____

Emergency Contact: Name:_____

Relationship:_____ **Phone (cell):** _____

Relationship Status: (check all that apply)

- □ Married
- □ Separated
- □ Divorced
- □ Dating
- □ Cohabitating
- □ Living together
- □ Living apart

Length of time in current relationship: _____

Is this your first marriage? □ Yes □ No

If not, list the number of prior marriages that you have had: _____

If you are divorced or separated, please describe your *past* relationship with your spouse:

_____

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern

- □ No concern
- □ Little concern
- □ Moderate concern
- □ Serious concern
- □ Very serious concern

Frequency

- □ No occurrence
- □ Occurs rarely
- □ Occurs sometimes
- □ Occurs frequently
- □ Occurs nearly always

What do you hope to accomplish through counseling?

_____

_____

_____

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 circling 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, when: _____ Where: _____
By whom: _____ Length of treatment: _____

Problems treated: _____

_____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in *individual* counseling before? □ Yes □ No

If yes, give a brief summary of concerns that you addressed.

_____
_____
_____

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

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

_____
_____
_____

Have either you or your partner struck, physically restrained, 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 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, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? _____times

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

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

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)

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

Please circle any of the following problems that pertain to your current situation:

- Nervousness
- Shyness
- Separation
- Drug use/alcohol
- Anger
- Sleep
- Legal matters
- Trauma
- Loneliness
- In laws
- Children
- Depression
- Sexual problems
- Other: _____
- Self-control
- Stress
- Headaches
- Memory
- Insomnia
- Inferiority Feelings
- Career Choices
- Nightmares
- Appetite
- Being a Parent
- Health
- Marital/Relationship
- Digestion Problems
- Fears
- Suicidal Thoughts
- Finances
- Friends
- Unhappiness
- Work
- Fatigue
- Legal
- Making Decisions
- Concentration
- Eating Disorder
- Thoughts

List all family members and others who are currently living in your home:

Name	Relationship	Age	Occupation

Rank order the top 3 concerns that you have in your relationship with your partner (#1 being the most problematic):

1._____

2._____

3._____

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.