Solid Ground Counseling

9401 Haggerty Road
Plymouth MI, 48170
734-927-1201

Couples Intake Form

Name:_____ Date:_____

Address:_____ City:_____ State:_____ Zip code:_____

Home Phone:_____ Mobile:_____ Email:_____

Name of Partner:_____

Relationship Status: (check all that apply)

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Dating: not engaged
- ☐ Cohabitating
- ☐ Living together
- ☐ Living apart
- ☐ Dating: Engaged

Length of time in current relationship: _____

Briefly describe the issues that bring you to counseling:

_____

_____

_____

Given these problems, what level of concern do you regarding the status of your relationship?

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

What do you hope to accomplish through counseling?

_____

_____

_____

What have you already done to deal with the problems?

_____

_____

_____

What are you biggest strengths as a couple?

_____

_____

_____

Please rate your current level of relationship happiness by circling the appropriate number.

1 2 3 4 5 6 7 8 9 10

Extremely unhappy Extremely happy

Have you received prior couples counseling? ☐ Yes ☐ No

If yes, when:_____ Length of treatment_____

Problems treated:

_____

_____

What was the outcome?

☐ Very successful ☐ Somewhat successful ☐ No change ☐ Worse ☐ Much worse

Has either partner been in *Individual* counseling before? ☐ Yes ☐ No

If yes, briefly explain:

_____

_____

Does either partner drink alcohol to intoxication or take drugs for intoxication? ☐ Yes ☐ No

If yes, please identify the substance, amount, frequency, and user:

_____

_____

Has either partner struck, physically restrained, or used violence against the other? ☐ Yes ☐ No

If yes, please describe:

_____

_____

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

☐ Yes ☐ No If yes, who? ____Me ____Partner ____Both of us

If married, has either partner consulted with a lawyer about divorce?

☐ Yes ☐ No If yes, who? ____Me ____Partner ____Both of us

Are there signs that either partner has given up on the relationship?

☐ Yes ☐ No If yes, who? ____Me ____Partner ____Both of us

How frequently have you had sexual relations during the past month? _____

How enjoyable is your sexual relationship?

1 2 3 4 5 6 7 8 9 10 N/A

Extremely unhappy Extremely happy

What is the current level of overall stress?

1 2 3 4 5 6 7 8 9 10

Very little stress Extremely stressful

What is the current level of stress in the relationship?

1 2 3 4 5 6 7 8 9 10

Very little stress Extremely stressful

How important is spirituality in your relationship?

1 2 3 4 5 6 7 8 9 10

Not important Extremely important

If important, briefly describe your spirituality:

_____

_____

Would you like spirituality incorporated into your treatment? ☐ Yes ☐ No

Is there any other information you would like your therapist to be aware of?

_____

_____

_____

_____

_____/_____ _____

Client's signatures Date

_____ _____

Therapist signature Date