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Family Couples Intake

Name:_____ Date: _____
Name of Partner:_____

Relationship Status: (check all that apply)
□ Married □ Separated □ Divorced □ Dating □ Cohabitating □ Living together □ Living apart

Length of time in current relationship: _____

What would you state as your primary reason for coming to therapy now?
_____
_____
_____

Rate your level of concern in regard to your primary concern:
□ No concern □ Little concern □ Moderate concern □ Serious concern □ Very serious concern

Rate your level of frequency in regard to your primary concern:
□ 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?
_____
_____
_____

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Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.
(extremely unhappy) 1 2 3 4 5 6 7 8 9 10 (extremely unhappy)

Please make at least one suggestion as to something you could personally do to improve the family relationship regardless of what your partner does.

_____
_____
_____

Have you received prior 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 so, give a brief summary of concerns that you addressed.

_____
_____
_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person? Please explain when, who, frequency and outcome.

_____
_____
_____

Has either of you threatened to separate or divorce (if married) as a result of the current problems?
If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?
If yes, who? ___Me ___Partner ___Both of us

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Do you perceive that either you or your partner has withdrawn from the family?
If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

What is your current level of stress (overall)? (Circle one)
(no stress) 1 2 3 4 5 6 7 8 9 10 (high stress)

What is your current level of stress (in the family)? (Circle one)
(no stress) 1 2 3 4 5 6 7 8 9 10 (high stress)

How committed are you to this family? (Circle one)
(extremely uncommitted) 1 2 3 4 5 6 7 8 9 10 (extremely committed)

How hopeful are you that your family can be what you want it to be? (Circle one)
(extremely unhopeful) 1 2 3 4 5 6 7 8 9 10 (extremely hopeful)

How able are you to feel like you hold onto yourself within your family? (Circle one)
(extremely unable) 1 2 3 4 5 6 7 8 9 10 (extremely able)

Rank order the top three concerns that you have in your family relationships
(1 being the most problematic):
1. _____
2. _____
3. _____

Please list any children/age and their parents if different from you and your current partner:
_____
_____

Briefly describe the history of this relationship (meeting, length of dating, commitment, cohabitation, marriage and children).
_____
_____
_____
_____
_____
_____

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How able are you to calm your own anxieties when things are rough in family relationships?

_____
_____
_____

Is there any history of affairs? Confirmed or suspected? Explain

_____
_____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION (Please circle one)
1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____
_____
_____

2. How would you rate your current sleeping habits?
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____
_____

3. Please list any difficulties you experience with your appetite or eating patterns.

_____
_____
_____

4. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

6. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe? _____

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7. How often do you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
How much?
_____

8. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
Which drugs and how much? _____

9. Has your use of substances changed recently? □ No □ Yes

Has anyone made a comment or complaint about your use? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse □ Yes □ No
_____
Anxiety □ Yes □ No
_____
Depression □ Yes □No
_____
Domestic Violence □ Yes □ No
_____
Eating Disorders □ Yes □ No
_____
Obesity □ Yes □ No
_____
Obsessive Compulsive Behavior □ Yes □ No
_____
Schizophrenia □ Yes □ No
_____
Suicide Attempts □ Yes □ No

_____