RESTORATION COUNSELING
COUPLES COUNSELING INTAKE FORM

TO BE COMPLETED BY BOTH PARTNERS

COUPLE INFORMATION

Name:_____ **Date:** _____

Name of Partner:_____

Mailing Address_____

City_____ **State** _____ **Zip Code** _____

Phone #:

Cell _____

Work _____

Email Address:

_____

Date of Birth _____ **Age** _____

Please list children and their ages: (if applicable)

_____

_____

Occupation _____

Employer_____

City _____ **State** _____

How or from whom did you hear of Restoration Counseling?

☐Physician ☐Church/Pastor ☐Friend

☐Web Search ☐Other

In Case of Emergency, contact _____

Phone #_____

Physician _____

Phone # _____

Relationship Status: (check all that apply)

☐Married ☐Separated☐Divorced ☐Dating

☐Cohabitating ☐Living together ☐Living apart

Length of time in current relationship: _____

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?

Frequency

☐No occurrence ☐Occurs rarely ☐Occurs sometimes

☐Occurs frequently ☐Occurs nearly always

Concern

☐No concern ☐Little concern ☐Moderate concern

☐Serious concern ☐Very serious concern

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

1._____

2._____

3._____

What do you hope to accomplish through counseling?

_____

_____

What have you already done to deal with the difficulties?

_____

_____

What are your greatest strengths as a couple?

_____

_____

Please rate your current level of relationship happiness by checking 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)

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

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

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?

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?

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

Do you perceive that either you or your partner has withdrawn from the relationship?

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? (check 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? (check one)

☐1 ☐2 ☐3 ☐4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
(extremely unsatisfied) (extremely satisfied)

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

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

What is your current level of stress (in the relationship)? (check one)

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

Thank you for taking the time to complete this intake form.