



## Confidential Couples Counseling Intake Form

Please fill out this form to help us know more about you and to ensure your counseling sessions focus on what is most important to you. Information provided is confidential as outlined in the Professional Disclosure Statement, the counseling office policies, and HIPPA Notice of Privacy posted online at [pillarsofhopecounseling.com](http://pillarsofhopecounseling.com). We would be happy to discuss those with you.

Name \_\_\_\_\_ Date \_\_\_\_\_

Name of Partner: \_\_\_\_\_

Address \_\_\_\_\_ City/ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact # \_\_\_\_\_ Alternative # \_\_\_\_\_

OK to leave messages at these phone numbers?  Yes  No OK to text these numbers?  Yes  No

\*Please note email and/or texting is not considered confidential communication.

Email \_\_\_\_\_ Partner's Email \_\_\_\_\_

Date & Place of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender:  F  M

Partner's Date & Place of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender:  F  M

Your current relationship status:  Married  Separated  Divorced  Dating  Cohabiting  Living together

Length of time in current relationship: \_\_\_\_\_

Are either of you currently attending school?  Yes  No Please check all degrees earned from the list below.

High School Diploma or  GED Year \_\_\_\_\_

Associates Degree Year \_\_\_\_\_  Associates Degree Year \_\_\_\_\_

Undergraduate Degree Year \_\_\_\_\_  Undergraduate Degree Year \_\_\_\_\_

Master Degree Year \_\_\_\_\_  Master Degree Year \_\_\_\_\_

PhD Degree Year \_\_\_\_\_  PhD Degree Year \_\_\_\_\_

Current Employer \_\_\_\_\_ Position \_\_\_\_\_ Length of Service \_\_\_\_\_

Current Employer \_\_\_\_\_ Position \_\_\_\_\_ Length of Service \_\_\_\_\_

Emergency contact person \_\_\_\_\_ Relationship \_\_\_\_\_

Referral source or how you came here: \_\_\_\_\_

List any health concerns \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List current medications:

Medication	Dosage	Start Date	Who

Describe any past or present drug/ alcohol use/abuse or treatments. \_\_\_\_\_

Describe any suicide attempts or violent behavior. \_\_\_\_\_

Have you or your partner received counseling before?  Yes  No (If "yes" please provide the reason and with whom) \_\_\_\_\_

What is the primary reason for seeking couples therapy? \_\_\_\_\_

What are or have you been doing to deal with your current relationship concerns? \_\_\_\_\_

Describe your strengths as a couple. \_\_\_\_\_

Please rate your current level of happiness with the relationship/marriage. (1= extremely unhappy and 10= extremely happy).

1      2      3      4      5      6      7      8      9      10

Please rate how stressful the relationship feels. (1= extremely unhappy and 10= extremely happy).

1      2      3      4      5      6      7      8      9      10

Please rate your current level of sexual satisfaction. (1= extremely unhappy and 10= extremely happy).

1      2      3      4      5      6      7      8      9      10

Has either partner threatened or begun divorce proceedings?  Yes  No If yes, who? \_\_\_\_\_

Have you received couples counseling or marriage therapy previously?  Yes  No If yes what was the outcome? \_\_\_\_\_

*Thank you for completing this form*