COUPLES THERAPY INTAKE

Date: ___ Therapist: _____

Partner 1: ____ *Age:* __ DOB: _____

Partner 2: ____ *Age:* __ DOB: _____

Relationship Length: ___ Living Together: ☐ Yes ☐ No

Married: ☐ Yes ☐ No **Date: _ Previous Marriages:** ☐ Yes ☐ No

Children Together: ☐ Yes ☐ No **Ages: _____**

Other Children: ☐ Yes ☐ No **Ages/Custody: _____**

PRESENTING CONCERNS

What brings you to couples therapy?

Partner 1's Main Concerns:

Partner 2's Main Concerns:

Current Relationship Issues (Check all that apply): ☐ Communication problems ☐ Frequent arguments ☐ Lack of intimacy ☐ Sexual issues ☐ Trust issues ☐ Infidelity ☐ Financial disagreements ☐ Parenting conflicts ☐ In-law problems ☐ Work-life balance ☐ Substance use ☐ Mental health issues ☐ Different values/goals ☐ Emotional distance ☐ Jealousy ☐ Domestic violence ☐ Separation/divorce ☐ Other: _____

When did problems begin? _____

What triggered current crisis? _____

Severity of problems (1-10): Partner 1: _ **Partner 2:** ___

RELATIONSHIP HISTORY

How did you meet? _____

What attracted you to each other? _____

Best times in your relationship:

Major relationship milestones:

Previous separations: ☐ None ☐ Yes - When/Why: ____

Previous couples therapy: ☐ None ☐ Yes - When/Outcome: ____

COMMUNICATION PATTERNS

How do you typically handle disagreements? Partner 1: _____ **Partner 2:** _____

Communication Styles: Partner 1: ☐ Direct ☐ Indirect ☐ Aggressive ☐ Passive ☐ Withdrawn Partner 2: ☐ Direct ☐ Indirect ☐ Aggressive ☐ Passive ☐ Withdrawn

During arguments, do you: ☐ Listen to each other ☐ Interrupt frequently ☐ Raise voices ☐ Name-call ☐ Bring up past issues ☐ Threaten to leave ☐ Give silent treatment ☐ Walk away ☐ Resolve issues ☐ Avoid conflict

How do you show love/appreciation? Partner 1: _____ **Partner 2:** _____

How do you prefer to receive love/appreciation? Partner 1: _____ **Partner 2:** _____

INTIMACY AND SEXUALITY

Physical Intimacy: ☐ Very satisfied ☐ Satisfied ☐ Somewhat satisfied ☐ Dissatisfied ☐ Very dissatisfied

Frequency of sexual intimacy: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Sexual satisfaction: Partner 1: ☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied Partner 2: ☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

Sexual concerns: ☐ None ☐ Mismatched desire ☐ Performance issues ☐ Pain during sex ☐ Lack of communication ☐ Past trauma affecting intimacy ☐ Other: _____

Emotional Intimacy: ☐ Very close ☐ Close ☐ Somewhat close ☐ Distant ☐ Very distant

Do you feel emotionally safe with your partner? Partner 1: ☐ Yes ☐ Sometimes ☐ No Partner 2: ☐ Yes ☐ Sometimes ☐ No

INDIVIDUAL BACKGROUNDS

Partner 1: Occupation: __ ***Education:*** ____ **Mental Health History:** ☐ None ☐ Depression ☐ Anxiety ☐ Other: _ ***Substance Use: ☐ None ☐ Alcohol ☐ Drugs ☐ Details: _ Previous Relationships: ☐ None ☐ Few ☐ Many ☐ Significant:*** ____ **Family of Origin:** ☐ Stable ☐ Divorced ☐ Conflicted ☐ Abusive

Partner 2: Occupation: __ ***Education:*** ____ **Mental Health History:** ☐ None ☐ Depression ☐ Anxiety ☐ Other: _ ***Substance Use: ☐ None ☐ Alcohol ☐ Drugs ☐ Details: _ Previous Relationships: ☐ None ☐ Few ☐ Many ☐ Significant:*** ____ **Family of Origin:** ☐ Stable ☐ Divorced ☐ Conflicted ☐ Abusive

FAMILY AND SOCIAL SUPPORT

Children in Home: Name: ___ **Age:** ***Relationship:*** ___ **Name:** __ ***Age:*** **Relationship:** ___ ***Name:*** ____ Age: _ **Relationship:** _____

Parenting Styles: Partner 1: ☐ Authoritative ☐ Permissive ☐ Strict ☐ Inconsistent Partner 2: ☐ Authoritative ☐ Permissive ☐ Strict ☐ Inconsistent

Parenting Conflicts: ☐ None ☐ Discipline ☐ Rules ☐ Activities ☐ Screen time ☐ Chores ☐ Other: _____

Extended Family Relationships: ☐ Supportive ☐ Neutral ☐ Interfering ☐ Conflicted ☐ No contact

Social Support: ☐ Strong ☐ Moderate ☐ Limited ☐ Isolated

Couple Friends: ☐ Many ☐ Some ☐ Few ☐ None

LIFESTYLE AND VALUES

Financial Situation: ☐ Comfortable ☐ Managing ☐ Struggling ☐ Crisis

Financial Management: ☐ Joint decisions ☐ One person manages ☐ Separate finances ☐ Conflict area

Religious/Spiritual Beliefs: Partner 1: ☐ Very important ☐ Somewhat important ☐ Not important Partner 2: ☐ Very important ☐ Somewhat important ☐ Not important ☐ Same beliefs ☐ Different beliefs ☐ Source of conflict

Life Goals: ☐ Aligned ☐ Somewhat aligned ☐ Different ☐ Conflicting

Work-Life Balance: ☐ Good balance ☐ Some issues ☐ Major problems

Household Responsibilities: ☐ Shared equally ☐ Mostly Partner 1 ☐ Mostly Partner 2 ☐ Source of conflict

RELATIONSHIP STRENGTHS

What do you appreciate about your partner? Partner 1 about Partner 2: _____ **Partner 2 about Partner 1:** _____

Relationship Strengths: ☐ Good communication ☐ Shared values ☐ Physical attraction ☐ Emotional support ☐ Shared interests ☐ Good teamwork ☐ Sense of humor ☐ Commitment ☐ Trust ☐ Respect ☐ Other: _____

Fun Activities Together:

What originally brought you together that still exists?

SAFETY ASSESSMENT

Domestic Violence: ☐ None ☐ Verbal threats ☐ Physical violence ☐ Sexual coercion ☐ Emotional abuse ☐ Financial abuse ☐ Stalking

Do you feel safe in this relationship? Partner 1: ☐ Yes ☐ Sometimes ☐ No Partner 2: ☐ Yes ☐ Sometimes ☐ No

Substance Use Impact: ☐ No impact ☐ Some problems ☐ Major problems ☐ Safety concerns

THERAPY GOALS

What would you like to achieve in couples therapy? Partner 1: 1. _____ *2.* _____ 3. _____

Partner 2: 1. _____ *2.* _____ 3. _____

Shared Goals: 1. _____ *2.* _____ 3. _____

Motivation for Therapy: Partner 1: ☐ Very motivated ☐ Motivated ☐ Ambivalent ☐ Reluctant Partner 2: ☐ Very motivated ☐ Motivated ☐ Ambivalent ☐ Reluctant

Commitment to Relationship: Partner 1: ☐ Fully committed ☐ Committed ☐ Uncertain ☐ Considering leaving Partner 2: ☐ Fully committed ☐ Committed ☐ Uncertain ☐ Considering leaving

CLINICAL OBSERVATIONS

Interaction Patterns Observed:

Communication Style in Session:

Emotional Presentation:

Therapeutic Alliance:

TREATMENT RECOMMENDATIONS

Recommended Approach: ☐ Emotionally Focused Therapy ☐ Gottman Method ☐ Cognitive-Behavioral ☐ Solution-Focused ☐ Narrative Therapy ☐ Other: _____

Session Format: ☐ Conjoint sessions only ☐ Individual sessions as needed ☐ Combination approach

Frequency: ☐ Weekly ☐ Bi-weekly ☐ Other: _____

Estimated Duration: _____

Additional Referrals: ☐ Individual therapy ☐ Psychiatric evaluation ☐ Medical evaluation ☐ Financial counseling ☐ Legal consultation ☐ Other: __

Partner 1 Signature: _____ **Date:** ____

Partner 2 Signature: _____ **Date:** ____

Therapist Signature: _____ **Date:** ____

This information is confidential and protected by HIPAA regulations.