Ashley Mullica, MSW, LCSW

COUPLES INTAKE FORM

Each partner please complete your own intake form and bring to your first session (one for each of you). Please note that the information you provide here is protected as confidential information.

Name:_____
Last First Middle Initial

Date of Birth:_____/_____/_____ **Age:**_____ **Gender:**_____

Address:_____
Number Street City State Zip

Home Phone:_____ **Cell Phone:**_____

Email:_____ **May I email you? Y N**
***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Preferred method of contact: Cell Phone Home Phone Email Text

Relationship Information

1. Please indicate your relationship status: ☐Married/Partnered ☐ Dating ☐ Separated ☐ Divorced ☐ Cohabiting ☐ In a relationship ☐ Other: _____

2. Briefly tell me about the issues/concerns that have brought you here. Why are you seeking couples counseling at this time?_____

_____

_____

3. Have you been married or partnered before? ☐ Yes ☐ No (if yes, # of times?) _____

4. How long have you and your current partner been in this relationship? _____

5. Are you and your partner presently living together? ☐ Yes ☐ No

6. Are you and your partner engaged to be married? ☐ Yes ☐ No If yes, when? _____

If not, is this a source of conflict? ☐ Yes ☐ No ☐ Maybe

7. Please fill in the percentages to indicate your amount of satisfaction and commitment:

I am _____ % committed to staying in our relationship.

I am _____ % satisfied in our relationship.

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8. On a scale 1 to 10, how would you rate your current level of happiness in your relationship? _____

9. If neither you nor your partner has children, please move on to Question #10. If either you or your partner have children, please fill out the following information for each child:

	Child's name	Age	Whose child?	Lives with whom?
1.	_____	____	_____	_____
2.	_____	____	_____	_____
3.	_____	____	_____	_____
4.	_____	____	_____	_____

10. Please check any current or past topics that are relevant to your relationship. If not applicable, leave blank. (C = currently P = in the past)

____Alcohol/problematic substance use
____Anger
____Commitment
____Communication
____ Conflict resolution
____ Controlling
____ Criticism
____ Defensiveness
____ Degrading comments
____ Divorce
____Emotional closeness
____ Family responsibilities
____ Finances
____ Flirting with others
____ Gambling
____ Getting engaged
____ Honesty
____ Housework/chores
____ Infidelity
____ Intimacy/affection
____ Jealousy
____ Lying
_____ Parenting
_____ Past relationships
_____ Perfectionism
_____ Physical attraction
_____ Fertility/Pregnancy
_____ Sex life
_____ Spirituality/religion
_____ Technology use
_____ Time together
_____ Trust
_____ Violence
_____ Working too much

11. If conflicts or fights are NOT an issue, please move on to Question #12. If they are an issue, please select the appropriate response for each:

Behavior	By Me:	By Partner:	Source of Conflict?
Breaking/Throwing Things	☐	☐	☐
Bringing up the Past	☐	☐	☐
Criticizing	☐	☐	☐
Leaving the House	☐	☐	☐
Name-Calling	☐	☐	☐
Physical Abuse	☐	☐	☐
Screaming	☐	☐	☐
Slamming Doors	☐	☐	☐
Speaking Irrationally	☐	☐	☐
Threatening Breaking up	☐	☐	☐
Threatening Taking the Kids	☐	☐	☐
Verbal Abuse	☐	☐	☐

12. Do you feel as though your temper adversely affects your relationship? ☐ Yes ☐ No
Your partner's temper? ☐ Yes ☐ No

13. Do you feel as though your mood adversely affects your relationship? ☐ Yes ☐ No
Your partner's mood? ☐ Yes ☐ No
If you answered yes to either, which moods? _____

13. Have you ever been verbally abusive to your partner? ☐ Yes ☐ No ☐ I don't know
Has your partner ever been verbally abusive to you? ☐ Yes ☐ No ☐ I don't know

14. Have you ever been physically abusive to your partner? ☐ Yes ☐ No ☐ I don't know
Has your partner ever been physically abusive to you? ☐ Yes ☐ No ☐ I don't know

15. It is my policy that if an affair or inappropriate outside relationship is revealed, that the individual will be expected to disclose this information during the course of couples counseling.
Have you ever had an affair (or inappropriate outside relationship) during your current relationship? ☐ Yes ☐ No If yes, is the affair current? ☐ Yes ☐ No
Has your partner ever had an affair (or inappropriate outside relationship) during your current relationship? ☐ Yes ☐ No If yes, is the affair current? ☐ Yes ☐ No

16. Have you ever been in couples therapy before? ☐ Yes ☐ No
If yes, what was the therapist's name? _____
What was the experience like? _____

Individual Information

17. Please check any current or past topics that are relevant to you individually:

___ Eating disorders/body image
___ Work Issues
___ Financial Stress
___ Perfectionism
___ Technology use
___ Phobias (type(s): _____)
___ Sadness/depression
___ Chronic pain/illness (type(s): _____)
___ Childhood abuse (physical, sexual, emotional)
___ Sexual assault/rape
___ Recently (when: _____)
___ In the past
___ Alcohol/problematic substance use
___ Gambling
___ Death of someone close
___ Recently (when: _____)
___ In the past
___ Other: _____

___ Culture/identity
___ Spirituality/religion
___ Trust
___ Libido/sex drive
___ Stress/anxiety
___ Fertility/pregnancy
___ Parenting
___ Infidelity
___ Domestic violence/abuse
___ Family (ie. divorce, alcoholism)
___ Relationships
___ Family
___ Friend
___ Parent
___ Significant other
___ Roommate
___ Coworker

18. Are there any physical health concerns of yours that may be relevant to couples counseling?
_____

19. Current medications (all, including herbal): _____

20. Are you currently working with a psychiatrist? ☐ Yes ☐ No
If yes, what is your psychiatrist's name? _____ Phone: _____
What is the psychiatrist treating you for? _____

21. Have you been on any medications in the past for mental health issues? ☐ Yes ☐ No
If yes, please list: _____

22. Have you previously seen a therapist? ☐ Yes ☐ No
Who/Where? _____ How long ago? _____
For what types of issues? _____

23. Are you currently/recently seeing any kind of therapist/healer? _____

24. Have you ever been hospitalized for physical or mental health issues? ☐ Yes ☐ No
If yes, briefly describe: _____

25. Have you had any previous suicide attempts? ☐ Yes ☐ No
If yes, briefly describe: _____

26. If you are currently experiencing any of the following symptoms, please rate them using the number key below:

Never 0 Seldom 1 Often 2 Always 3

___ Difficulty concentrating	**___ Memory loss or blackouts**	**___ Crying**
___ Difficulty sleeping	**___ Missing work/class**	**___ Stealing**
___ Feeling helpless	**___ Anger**	**___ Negativity**
___ Jealousy	**___ Feeling uptight/tense**	**___ Eating binges**
___ Worrying	**___ Drinking heavily**	**___ Feeling hopeless**
___ Problematic drug use	**___ Feeling afraid**	**___ Feelings of guilt**
___ Lying to others	**___ Social Withdrawal**	**___ Feeling out of control**
___ Sexual preoccupation	**___ Feelings of self-doubt**	**___ Low sex drive**
___ Self Injury/Cutting	**___ Suicidal thoughts**	**___ Loneliness**

___ Physical symptoms (i.e. headaches, digestive) **___ Nervousness around others**
List: _____
Have you seen a health care provider for your symptoms?_____
___ Other:_____

Is there anything else you'd like me to know about you? _____
_____
_____