



Couples Counseling Initial Intake Form for Mithrah Holistic Services

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Full Name: _____ Date: _____

Full Name of Partner: _____

Relationship Status: (check all that apply) Married Separated Divorced Dating Cohabiting 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?

Concern No concern Little concern Moderate concern Serious concern

Very serious concern Frequency 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.

1 2 3 4 5 6 7 8 9 10 (1-extremely unhappy) (10-extremely happy)

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

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? (Circle one)

1 2 3 4 5 6 7 8 9 10 (1 extremely unpleasant) (10 extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

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

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



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

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

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

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

1. _____

2. _____

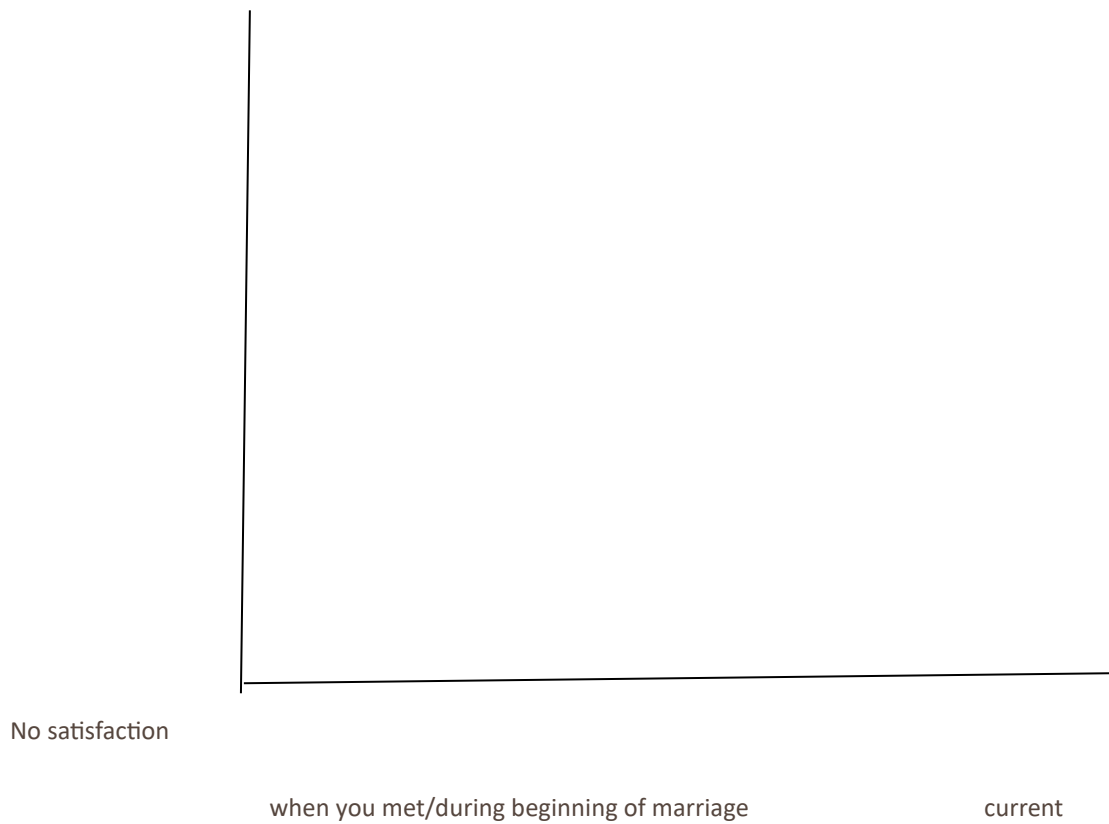
3. _____

Please use the space below to include anything you believe will be useful for the therapy :



Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note pivotal/significant events in your relationship (e.g., one of you moved out, one of you cheated).

complete satisfaction



Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.

Prepared for Mithrah Holistic Services – www.mithrah.com

