Family Restoration
COUNSELING SERVICES

Confidential Couples Intake

Please fill this form out individually

Welcome to Family Restoration Counseling Services! We are honored to be a part of your journey. Please take time to fill out this form to the best of your ability. This form is confidential and will be reviewed by your therapist before your first session.

Name _____ Age _____ Date of Birth _____ Gender _____

Street Address _____ City _____ State _____ Zip _____

Email Address _____ Referred By _____

Home Phone _____ May we contact you by this number? ◯ No ◯ Yes

Cell Phone _____ May we contact you by this number? ◯ No ◯ Yes

Work Phone _____ May we contact you by this number? ◯ No ◯ Yes

Current Employment Status _____ Position _____ Employer _____

Current Relationship Status (check all that apply):

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Dating/Committed Relationship ☐ Living Together ☐ Living Apart

Household Members: Please include all individuals currently living with you.

Name of Household Member	Age	Relationship to You

Mental Health History

Have you previously received any type of mental health services for yourself (counseling, psychiatric services, etc.)?

◯ No ◯ Yes _____ _____ _____

If yes, name of clinician | Phone | Date of Services

If necessary to coordinate treatment, may your therapist contact this clinician?

◯ No ◯ Yes _____ _____

Client Signature | Date

In the section below, identify any family history of the following conditions. If yes, please indicate the family member's relationship to you in the space provided (sister, father, grandmother, etc.).

Alcohol/Substance Abuse	◯ Yes	◯ No	_____
Anxiety	◯ Yes	◯ No	_____
Depression	◯ Yes	◯ No	_____
Domestic Violence	◯ Yes	◯ No	_____
Eating Disorders	◯ Yes	◯ No	_____
Obesity	◯ Yes	◯ No	_____
Obsessive Compulsive Behavior	◯ Yes	◯ No	_____
Schizophrenia	◯ Yes	◯ No	_____
Suicide Attempts	◯ Yes	◯ No	_____

Medical History

Please list any significant illnesses, injuries, hospitalizations, or special medical needs.

_____

_____

_____

Current Medications

Are you currently taking any prescription medication?

◯ No ◯ Yes, as listed below:

Name of Medication	Dosage	Reason for Medication

Life History

Please describe any significant or stressful life events that have been impacting you.

Economic/financial problems: ◯ No ◯ Yes, described below:

_____

Difficulty accessing health care: ◯ No ◯ Yes, described below:

_____

Legal Issues/crime: ◯ No ◯ Yes, described below:

_____

Cultural/racial issues: ◯ No ◯ Yes, described below:

_____

Life History (Continued):

Please describe any current or past significant or stressful life events that have been impacting you.

Family conflict or lack of support: ◯ No ◯ Yes, described below:

_____

Social problems: ◯ No ◯ Yes, described below:

_____

Educational/occupational difficulties: ◯ No ◯ Yes, described below:

_____

Housing problems: ◯ No ◯ Yes, described below:

_____

Grief/loss: ◯ No ◯ Yes, described below:

_____

Other: ◯ No ◯ Yes, described below:

_____

Relationship History

Please answer the following questions **for the relationship you are seeking to address in counseling,** as you experience it:

Have you received couples counseling in the past? ◯ No ◯ Yes, described below:

_____ _____

Name of therapist & organization Dates of treatment

If necessary to coordinate treatment, may your therapist contact this clinician?

◯ No ◯ Yes

_____ _____

Client Signature Date

Relationship History (Continued):

If you have received couples counseling before, why or why not was it successful?

How long have you been in this current relationship? _____

Was there a prompting event that made counseling seem like a good/necessary idea this time?

Who primarily wanted to start coming to therapy?

◯ Me ◯ My partner ◯ Both of us ◯ Someone else's idea

Please rate your **current level of relationship satisfaction:**

◯ Very Satisfied ◯ Somewhat Satisfied ◯ Somewhat Unsatisfied ◯ Very Unsatisfied

How satisfied are you with the **frequency of your sexual activities**?

◯ Very Satisfied ◯ Somewhat Satisfied ◯ Somewhat Unsatisfied ◯ Very Unsatisfied

How satisfied are you with the **quality of your sexual activities**?

◯ Very Satisfied ◯ Somewhat Satisfied ◯ Somewhat Unsatisfied ◯ Very Unsatisfied

What is your **current level of stress in the relationship**?

◯ Not Stressed ◯ Somewhat Stressed ◯ Moderately Stressed ◯ Very Stressed

What current issues/difficulties do you see in your relationship?

What have you already tried to address these issues?

Relationship History (Continued):

Have either of you **threatened to separate/divorce** due to relationship problems?

◯ No || Yes: ◯ Me ◯ My Partner ◯ Both of us

If married, have either of you **consulted with a lawyer about divorce**?

◯ No || Yes: ◯ Me ◯ My Partner ◯ Both of us

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

◯ No || Yes: ◯ Me ◯ My Partner ◯ Both of us

Have you or your partner ever **emotionally or physically cheated** on the other?

◯ No || Yes: ◯ Me ◯ My Partner ◯ Both of us

Have either of you or your partner **physically restrained, harmed, or injured** the other person (pushed, shoved, grabbed, slapped, etc.)

◯ No || Yes: ◯ Me ◯ My Partner ◯ Both of us

How important is it to you to improve the quality of your relationship?

◯ Very Important ◯ Somewhat Important ◯ Not Very Important ◯ Not At All Important

How willing are you to make "working on this relationship" a priority in your life?

◯ Willing ◯ Somewhat Willing ◯ Somewhat Reluctant ◯ Reluctant

What are your expectations for counseling?

Check all treatment objectives you hope to accomplish in counseling:

☐ Improve communication
☐ Problem solving
☐ More quality time together
☐ More respect/understanding
☐ More social contacts
☐ Unity on finances
☐ Conflict resolution
☐ More emotional intimacy
☐ Resolve individual issues
☐ Power and control issues
☐ More sharing of duties
☐ Building/recovering trust
☐ Parenting skills
☐ More sexual intimacy
☐ More independence
☐ More hobbies
☐ Help for children's behavior
☐ Other (please describe):

Relationship History (Continued):

What are the top three areas that you believe need to be addressed in therapy (in order from most problematic to least problematic)?

1.

2.

3.

Please make at least three (3) suggestions of changes you could personally do to improve the relationship, regardless of what your partner does:

1.

2.

3.

What are your biggest strengths as a couple?

Is there anything else you would like to mention?