Munn & Associates
5858 Mt. Alifan Drive #104
San Diego, CA 92111
619-971-8225 or fax 858-384-6042

Couples Counseling Initial Intake Form

Name: ____ **Date**: ______/_______/_____

Address:____

Phone #:____

Email:____

Name of Partner: ______________________________________

Partner's Address:_______________________________________

Partner's Phone#:____

Referred by (if any): ____

Relationship Status: (check all that apply)

□ Married □ Separated□ Divorced□ Dating□ Cohabitating□ 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?

____

____

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

(Extremely unhappy) (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? ________time/times

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10

(Extremely unpleasant) (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

(Extremely unsatisfied) (Extremely satisfied)

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

1 2 3 4 5 6 7 8 9 10

(No stress) (High stress)

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

1 2 3 4 5 6 7 8 9 10

(No stress) (High stress)

Rank order the top three concerns that you have in your relationship with your partner

(1 being the most problematic):

1. ____

2. ____

3. ____

The Problem

1. What are the recent events that brought you in today?

____

____

____

2. What have you done about it?

____

____
_
____
_

3. What can we do? (What are your expectations in coming here?

____
_
____
_
____
_

4. As you see yourself, what kind of person are you? Describe yourself.

____
_
____
_
____
_

5. What, if anything, do you fear?

____
_
____
_
____
_

6. Is there any other information we should know?

____
_
____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. What is your education level?

____

FAMILY MENTAL HEALTH HISTORY:

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

	Please Circle	List Family Member
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	

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in: _________________________________

4. Please list any difficulties you experience with your appetite or eating patterns.

____

5. Are you currently experiencing overwhelming sadness, grief or depression?

□ No

□ Yes

If yes, for approximately how long? ________________________

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No

□ Yes

If yes, when did you begin experiencing this? ___________________________

7. Are you currently experiencing any chronic pain?

□ No

□ Yes

If yes, please describe? ___________________________

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly

□ Infrequently □ Never

10. What is/are your drug of choice if you use either regularly or recreationally?

____

Thank you for completing this. 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 may not be shown this form.