

Live Oak Counseling & Associates, PLLC

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Couples Intake

Name: _____ **Date:** _____

Address: _____

Phone (cell): _____

Email: _____

Date of Birth: _____

Name of Partner: _____

Emergency Contact: _____

Relationship: _____ **Phone (cell):** _____

How did you hear about me: _____

Relationship Status: (check all that apply)

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Married | <input type="checkbox"/> Cohabiting |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Living together |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Living apart |
| <input type="checkbox"/> Dating | |

Length of time in current relationship: _____

Is this your first marriage? Yes No

If not, list the number of prior marriages that you have had:

If you are divorced or separated, please describe your *past* relationship with your spouse:

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 yes, give a brief summary of concerns that you addressed.

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

Yes No

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? Yes No

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?

Yes No If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

Yes No If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

Yes No If yes, which of you has withdrawn?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
(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)

Please circle any of the following problems that pertain to your current situation:

- Nervousness
- Shyness
- Separation
- Drug use/alcohol
- Anger
- Sleep
- Legal matters
- Trauma
- Loneliness
- In laws
- Children
- Depression
- Sexual problems
- Self-control
- Stress
- Headaches
- Memory
- Insomnia
- Inferiority Feelings
- Career Choices
- Nightmares
- Appetite
- Being a Parent
- Health
- Marital/Relationship
- Digestion Problems
- Fears
- Suicidal Thoughts
- Finances
- Friends
- Unhappiness
 - Work
- Fatigue
- Legal
- Making Decisions
- Concentration
- Eating Disorder
 - Thoughts

• Other: _____

List all family members and others who are currently living in your home:

Name	Relationship	Age	Occupation

Rank order the top 3 concerns that you have in your relationship with your partner (#1 being the most problematic):

1. _____

2. _____

3. _____

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 session but your partner will not be shown this form.