

Case Number: _____

**Family Counseling and Children's Services
Relationship Counseling Intake**

As a couple, please answer the questions collectively. If answers differ, please initial your responses. Please answer everything except for the boxed areas.

Were either of you a recent victim of trauma, abuse or neglect? If so, was there a protection plan discussed and developed? Were basic needs discussed and met?

What is the reason that you are seeking counseling? How long have you been experiencing this problem? What have you done to address this problem? What is your overall goal?

What is your current status? (Circle all that apply)

Dating Living Together Living Apart Married Separated Divorced

Conflicts over: (Check all of the items that apply)

- Friends
- Job
- Money
- Alcohol/Drugs
- Legal Problems
- Mental Health Problems
- In-Laws/Family
- Communication
- Sex
- Other, Describe: _____

Children (Including Biological, Adopted, Foster, Step)

Name	Sex	Age	Type	Custody (Legal/Physical)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Present Family

Names, Roles, Relationships, and Areas of Conflict with Household Members

With whom did you live with growing up? _____

Describe your relationship with your:

Mother: _____

Father: _____

Siblings: _____

Describe your parent's parenting style: _____

Describe your viewpoint of your parent's marriage: _____

Family of Origin:

Parents & Siblings (Names, Ages, Description of Relationship; Parent's Marital Status; Family History of Mental Illness, Substance Abuse, Sexual Abuse, Childhood or Adolescent Problems & Current Relationship Status.)

What jobs have you held in the past?

Job:	Length of Time:	Reason for Leaving:	Job Satisfaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is the highest grade your partner has completed: _____ Grade _____ GED _____ College

Is your spouse currently employed? If yes, position: _____

How long have you had this job? _____ Are you satisfied with job? _____

What jobs have your spouse held in the past?

Job:	Length of Time:	Reason for Leaving:	Job Satisfaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Educational/Vocational

How would you describe your general health? _____

Name of Physician: _____

Address: _____ Phone: _____

Check all of the following physical conditions that apply to you:

- | | |
|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> History of Sleep Problems | |
| <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Chest Pain | |
| <input type="checkbox"/> Seizures | |

How is your sleep? Good Fair Poor Explain: _____

Nutritional Problems? Yes No Specify: _____

Appetite: Good Fair Poor Explain: _____

Disability/Handicap? _____

Allergies? _____

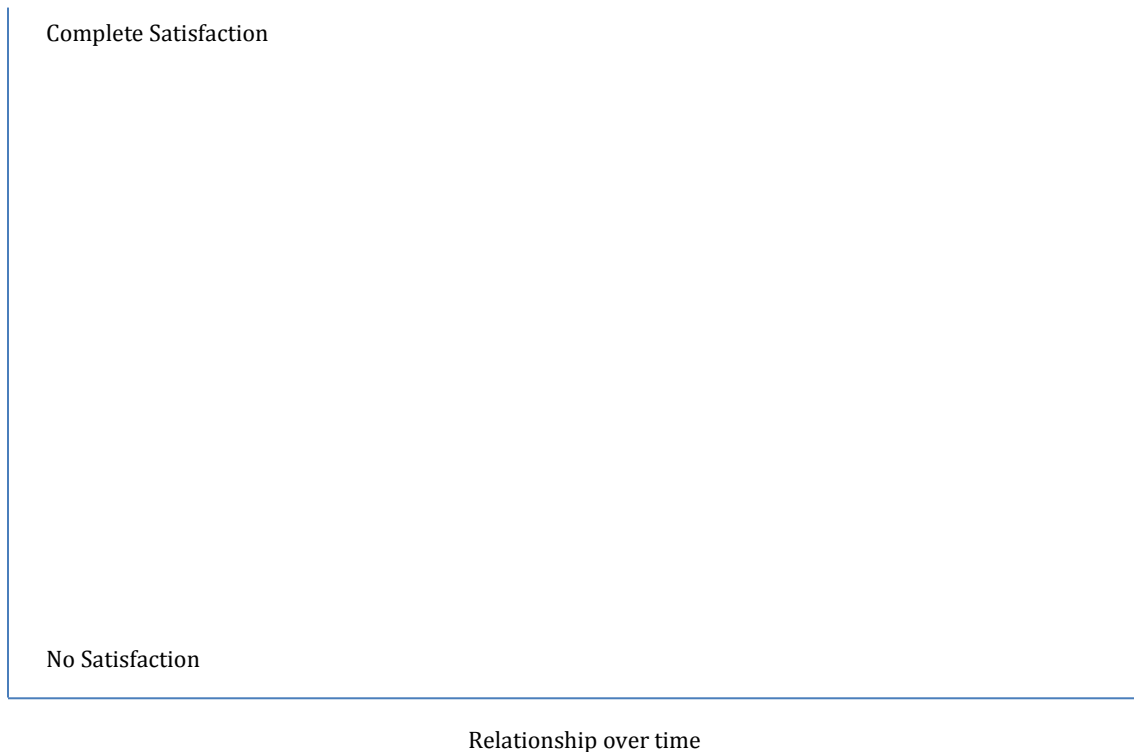
Medication Name	Reason for Taking	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History

Changes in Appetite; Average Sleep Duration & Consistency; Changes, Side Effects & Effectiveness of Medication

Please make at least one suggestion as to something you could personally do to improve the marriage, regardless of what your partner does? _____

Please draw a graph indicating your level of marital satisfaction beginning with when you met your partner. Note pivotal events in your relationship.



Please rate your current level of marital happiness by circling the number which corresponds with your current feelings about the relationship.

0	1	2	3	4	5	6
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

Have you ever been to counseling as a result of problems with this relationship prior to today? If so, what was the outcome of that counseling? _____

Has either of you threatened to separate or divorce as a result of the current relationship problems? If yes, have you consulted with a lawyer about separation or divorce?

Do you perceive that either you or your partner has withdrawn from the relationship? If yes, which of you has withdrawn? Are both of you committed to the counseling process? _____

Have either you or your partner been in counseling before? If so, give a brief summary? Did you think counseling was beneficial? Agency Name & City? Therapist name? Dates received counseling?

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 you or your partner struck, physical restrained, used violence against or injured the other person? If yes, who, how often and what happened? _____

How enjoyable is your sexual relationship? (Circle One)

Terrible More unpleasant than pleasant Not pleasant not unpleasant More pleasant than unpleasant Great

How frequently have you had sexual relations during the last month? _____

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

Way too often to suit me A bit too often for me About right A bit too seldom to suit me Way to seldom to suit me

What do you find the most satisfying about your sexual relationship? What do you find the least satisfying? How has your sexual relationship changed since you were first together? What is one thing that you wish were different about your sexual relationship? _____

What is your current level of stress? (Circle One)

Extremely High Very High High Moderate Low Very Low Extremely Low

To what degree do the two of you share a similar basic worldview? (Circle One)

Extremely High Very High High Moderate Low Very Low Extremely Low

To what degree do the two of you have family or friends that support you as a couple? (Circle One)

Extremely High Very High High Moderate Low Very Low Extremely Low

Do you have separate friendships with people who are not mutual friends? Does this create conflict in your relationship? _____

Are you comfortable doing activities away from your partner? How comfortable are you with your partner spending time away from you? _____

Do you spend time alone? Does this create conflict in your relationship? _____

What do you do when you get angry? What does your partner do? _____

Marital History

Intimate Relationship History (Duration of Relationship, Summary of Relationship Strengths and Areas of Conflict)

Have you ever been involved with the police or courts? No Yes, Explain: _____

Charge	Date	Outcome	Was this related to DV? Substance Abuse?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Legal Status

- Client denies any current suicidal or homicidal thoughts, feelings, gestures, intentions or plans.
- Client reports current suicidal or homicidal feelings. Specify: _____

- Client denies history of suicidal or homicidal thoughts, feelings, gestures, or plans.
- Client has history of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Suicidality/Homicidally:

MENTAL STATUS:

General Behavior: I.E. Cooperative, Passive, Withdrawn, Hostile, Anxious, Other _____
Attire: I.E. Appropriate, Seductive, Untidy, Loud, Meticulous, Other _____
Gait: I.E. Normal, Erect, Stooped, Ataxic, Rigid, Shuffling, Manneristic, Other _____
Motor Activity: I.E. Normal, Agitated, Retarded, Tic, Mannerism, Other _____

Stream of Thought and Communication:

Productivity: Spontaneous, Verbose, Pressured Speech, Unproductive, Other _____
Progression: Normal, Loose, Circumstantial, Preservation, Halting, Incoherent, Fragmented,
Other _____
Language: Normal, Baby Talk, Peculiar, Expressions, Rambling, Impediment, Verbose,
Profanity, Other _____

Emotional Tone and Reactions:

Mood/Affect: Indifferent, Fearful, Angry, Euphoric, Labile, Shallow, Blunted, Flat, Normal,
Composed, Anxious, Tearful, Depressed, Other _____

Mental Trend/Content of Thought:

Perception: Normal, Auditory, Hallucination, Visual Hallucinations, Illusions, Depersonalization,
Hypochondriasis, Delusions of Grandeur, Other _____
Orientation: Normal, Disorientation to Time, Place, Person, Other _____
Memory: Normal, Defective, (Remote, Recent, Immediate)
General Knowledge: Consistent with Education, Inconsistent, Explain if Needed _____

Insight: Absent, Good, Fair, Minimal

Judgment: Good, Fair, Poor

Diagnostic Summary:

DIAGNOSTIC IMPRESSION (DSM-5 Code and Diagnosis)
