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Couples Counseling Intake Form

Name: _____

Date: _____ 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 have you already done to deal with the difficulties?

What do you hope to accomplish through counseling?

What are your biggest strengths as a couple?

Please rate your current level of relationship happiness on a scale 1-10

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 _____

How successful was the outcome, on a scale 1-10 _____

Have 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? _____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?

Have 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? _____Yes _____No

If yes, who _____Me _____Partner _____Both

Do you perceive that either you or your partner has withdrawn from the relationship?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If yes, which of you has withdrawn?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

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

How enjoyable is your sexual relationship (Circle One)

Extremely unpleasant 1 2 3 4 5 6 7 8 9 10 Very Pleasant

How satisfied are you with the frequency of your sexual relations?

Extremely unsatisfied 1 2 3 4 5 6 7 8 9 10 Very Satisfied

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

No Stress 1 2 3 4 5 6 7 8 9 10 High Stress

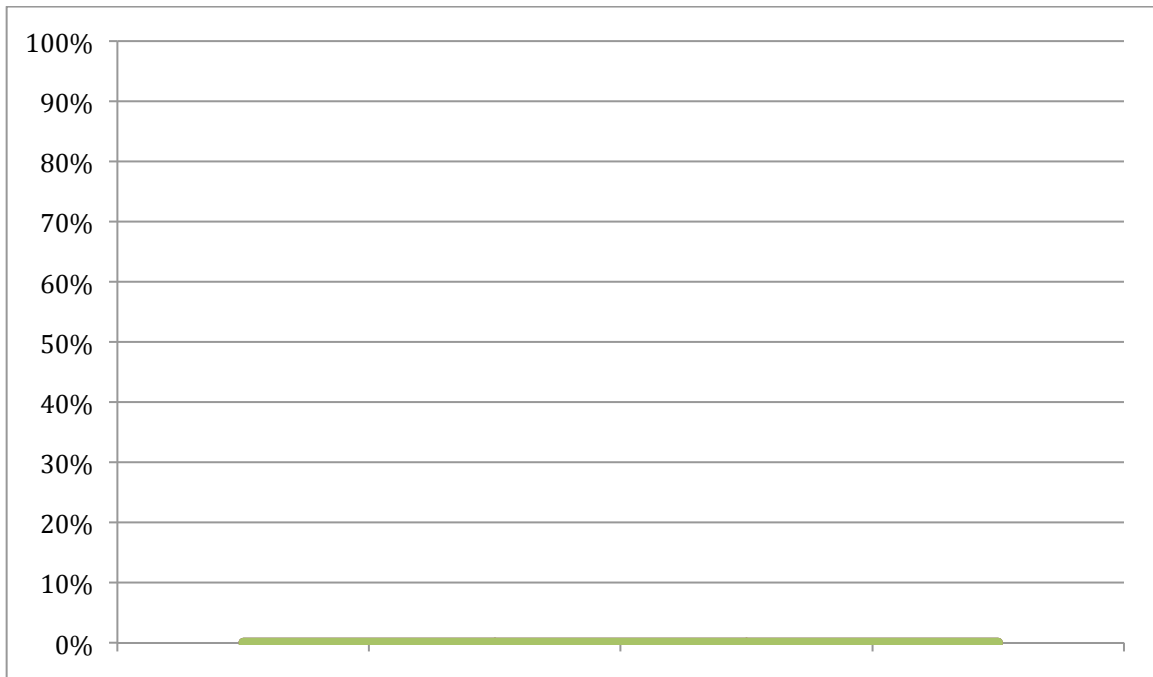
What is your current level of stress *overall*?

No Stress 1 2 3 4 5 6 7 8 9 10 High Stress

Rank order the top three concerns that you have in your relationship with your partner with 1 being the most problematic:

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



No Satisfaction

When you met/began dating, through your relationship over time

Is there anything more you would like to tell me?

What do you hope to accomplish during counseling?

Thank you for completing this. Please note that you may be asked to talk about your answers in sessions, but your partner will not be shown this form.