SUPPORTIVE SOLUTIONS
COUNSELING AND CONSULTING

Couples Counseling Intake Form

Name: _____

Address: _____

Telephone (primary and secondary): _____

Birthdate: _____ Occupation: _____

Spouse/Partner's Name: _____

Address (if different): _____

Telephone (primary and secondary): _____

Birthdate: _____ Occupation: _____

Relationship Status (check all that apply):

☐ Married ☐ Separated ☐ Divorced
☐ Dating ☐ Living together ☐ Living apart

Length of time in current relationship: _____

Children (including, biological, adopted, foster, step):
Name _____Sex _____ Age ____ Custody _____
Name _____Sex _____ Age ____ Custody _____
Name _____Sex _____ Age ____ Custody _____
Name _____Sex _____ Age ____ Custody _____

Please check any of the reasons listed below that resulted in your request for counseling:

☐ Depression or anxiety ☐ Alcohol/drug abuse ☐ Communication difficulties
☐ Improve sexual relations ☐ Child/parent conflict ☐ Divorce counseling
☐ Learning difficulties ☐ School/work problems ☐ Sexual orientation questions
☐ Family counseling ☐ Individual counseling ☐ Relationship enhancement
☐ Grief ☐ Thinking of harming self ☐ Thinking of harming others
☐ Pre-marital counseling ☐ Abuse (physical/mental/sexual)

What is your primary reason for seeking counseling at this time:_____
_____

What would you like to accomplish in counseling: _____
_____
_____

What have you already done to deal with the difficulties:_____
_____
_____

What are your biggest strengths as a couple:_____
_____
_____

Have either of you ever received counseling before? If yes, where, when, and with whom?
_____
_____

Referred by (if any): _____

Emergency contact (client 1): _____

Phone/Address: _____

Relationship: _____

Emergency contact (client 2): _____

Phone/Address: _____

Relationship: _____

Signed _____ Date _____

Signed _____ Date _____