

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: _____

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 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: _____

Length of treatment: _____

Problems treated: _____

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Do you perceive that either you or your partner has withdrawn from the relationship?

If yes, which of you has withdrawn?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? _____ times

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

1. _____
2. _____
3. _____