



Ferren Family Counseling LLC
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Couples Counseling Initial Intake Form

Name: _____

Birth Date: ____ / ____ / ____ Age: _____ Gender: _____ SSN: _____

Insurance: _____

ID#: _____ Group #: _____

Please list any children/age: _____

Address: _____

Home Phone: _____ May we leave a message? Yes No

Cell/Other Phone: _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____

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: _____

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 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?

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Do you perceive that either you or your partner has withdrawn from the relationship?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If yes, which of you has withdrawn?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

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?

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

Please provide a brief summary (optional).

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)

Rank order the top three concerns that you have in your relationship with your partner:

1. _____
2. _____
3. _____

Lastly, 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

Relationship over time

When you met/began dating

Current

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 sessions but your partner will not be shown this form.