dayspring

SUPPLEMENTAL COUPLES/MARRIAGE INTAKE FORM

Client's Name: _____ **Date:** _____

1. Have you ever been to counseling as a result of problems with this relationship prior to today? (Circle: Yes or No) If so, what was the outcome of that counseling?

2. Have either you or your partner been in individual counseling before? (Circle: Yes or No) If so, give a brief summary.

3. Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? (Circle: Yes or No) If yes for either, who, how often, and what drugs (or alcohol)?

4. Do you have any concerns about other compulsive/addictive behavior (i.e. gambling, sexual, spending, etc.)?

5. Have either you or your partner struck, physically restrained, used violence against or injured the other person within the last three years? (Circle: Yes or No)
   If yes for either, who, how often, and what happened?

6. Have either of you threatened to separate or divorce as a result of the current marital problems? (Circle: Yes or No) If yes, who?

7. Have you or your partner consulted a lawyer about divorce? (Circle: Yes or No)
   If yes, who?

8. Do you perceive that either you or your partner has withdrawn from the marriage? (Circle: Yes or No) If yes, which of you has withdrawn?

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

10. How enjoyable is your sexual relationship? (Check one)

- ☐ Terrible
- ☐ More unpleasant than pleasant
- ☐ Not pleasant, not unpleasant
- ☐ More pleasant than unpleasant
- ☐ Great

11. How satisfied are you with the frequency of your sexual relations? (Check one)

- ☐ Way too often to suit me
- ☐ A bit too often to suit me
- ☐ About right
- ☐ A bit too seldom to suit me
- ☐ Way too seldom to suit me

12. What is your current level of stress? (Check one)

- ☐ Extremely high
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low
- ☐ Extremely low

13. To what degree do you have family or friends that support you as a couple? (Circle one)

- ☐ Extremely high
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low
- ☐ Extremely low.

14. 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

Couples Personal Data Inventory

Client's Name _____

Address _____

Occupation _____

Home Phone _____ Business Phone _____

Cell Phone _____ Sex _____ Birth Date _____ Age _____

Marital Status: Single Going Steady Married Separated Divorced Widowed

Education (last year completed): _____ Grade: _____

Other training (list type and years) _____

_____

Referred by _____

Address _____

_____

Health Information:

List all important present or past illnesses, injuries, or handicaps:

_____

_____

_____

Are you presently taking medications? Yes No What? _____

Have you recently suffered the loss of someone dear to you? Yes No

Explain _____

_____

Have you recently suffered loss from serious social, business, or other reversals? Yes No

Explain _____

_____

Are you currently seeing a counselor or psychotherapist? Yes No

If yes, list the counselor or therapist _____

Religious Preference

What is your religious preference? _____

Place of worship _____

Are you a member? _____

Marriage Information

Name of Spouse _____

Address _____

Home Phone _____ Cell Phone _____

Occupation _____ Business Phone _____

Your spouse's Age _____ Education (in years) _____

Your spouse's Religion _____

Is your spouse willing to come for counseling? Yes No Uncertain

Have you ever been separated? Yes No Filed for divorce? Yes No

Date of marriage _____ Your ages when married: Husband _____ Wife _____

How long did you know your spouse before marriage? _____

Length of steady dating with your spouse _____

Length of engagement _____

Give brief information about any previous marriages _____

_____

_____

_____

Information about Children:

Name _____ *PM

Age _____ Sex _____ Living: Yes No

Education (in years) _____ Marital Status _____

Name _____ *PM

Age _____ Sex _____ Living: Yes No

Education (in years) _____ Marital Status _____

Name _____ *PM

Age _____ Sex _____ Living: Yes No

Education (in years) _____ Marital Status _____

_____

*Circle these letters if by previous marriage

Family History

Check the boxes below if you or any family members are currently experiencing, or have experienced any of the following:

	Self	Spouse	Mother	Father	Sister	Brother	Grandparents	Uncles	Aunts
Workaholic	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug Addiction or Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicide Threats or Attempts	☐	☐	☐	☐	☐	☐	☐	☐	☐
Overweight or Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anorexia Nervosa	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bulimia Nervosa	☐	☐	☐	☐	☐	☐	☐	☐	☐
Compulsive Overeating/Eating	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Hospitalization	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychotherapy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rape	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Incest	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emotional Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stealing or Shoplifting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Homosexuality	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rigid Religious Belief System	☐	☐	☐	☐	☐	☐	☐	☐	☐

The Problem

1. What are the recent events that brought you in today?

2. What have you done about it?

3. What can we do? (What are your expectations in coming here?)

4. As you see yourself, what kind of person are you? Describe yourself.

5. What, if anything, do you fear?

6. Is there any other information we should know?