Couple Intake Form

Wendy E. Smith, MA, LMHC
2212 Queen Anne Ave N, Box 304, Seattle, WA 98109
(206) 965-8749
www.wendysmithcounseling.com

Today's date:_____

Name:_____ Date of birth:_____ Age:_____

Address:_____

_____

Phone:_____ May I leave a message? Yes☐ No☐

Email:_____ Okay to use for scheduling? Yes☐ No☐

Occupation:_____

Education:_____

Religious affiliation, if any:_____

Ethnicity:_____

Other way you identify yourself that is important to you:_____

Have you ever received counseling, psychiatric, or drug or alcohol treatment before?
Yes☐ No☐ If yes, please explain:

Please list any physical health problems or disabilities of any kind you currently have and how long you have had them:

Name of partner:_____

If living together, how long? _____ If married, how long? _____

If there are children from this relationship, please indicate:
Name_____ Gender____ Age____
Name_____ Gender____ Age____
Name_____ Gender____ Age____
Name_____ Gender____ Age____

If previously married, please indicate:

Name of Spouse	Years Married	Date Marriage Ended	Reason

If there are children by previous marriage or relationship, please indicate:
Name_____ Gender____ Age____
Name_____ Gender____ Age____
Name_____ Gender____ Age____
Name_____ Gender____ Age____

If any brothers and sisters, including those deceased, please indicate:

Name	Age	Gender	Education	Occupation	Marital Status

Father's Name_____ Birthplace_____
Education_____ Occupation_____
Present Age_____If deceased, when?_____

Mother's Name_____ Birthplace_____
Education_____ Occupation_____
Present Age_____If deceased, when?_____

Was either parent married more than once? Please give details:

Name_____ Date_____

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, select one of the numbered descriptors that best describes HOW MUCH DISCOMFORT THAT PROBLEM CAUSED YOU DURING THE PAST WEEK, INCLUDING TODAY. Place the number in the space to the left of the problem. Respond to each problem listed. Please read the following example before beginning.

DESCRIPTORS
0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Extremely

Example:
In the previous week, how much were you distressed by:
3__ Body aches

In this example, the respondent experienced body aches quite a bit (3) in the previous week.

IN THE PREVIOUS WEEK, HOW MUCH WERE YOU DISTRESSED BY:

SZ

____ Headaches
____ Faintness or dizziness
____ Pains in heart or chest
____ Pains in lower back
____ Nausea or upset stomach
____ Soreness of your muscles
____ Trouble getting your breath
____ Hot or cold spells
____ Numbness or tingling in parts of your body
____ A lump in your throat
____ Feeling weak in parts of your body
____ Heavy feelings in your arms or legs

0 ____ **TOTAL**

DC

____ Repeated unpleasant thoughts, words, or ideas that won't leave your mind
____ Trouble remembering things
____ Worried about sloppiness or carelessness
____ Feeling blocked in getting things done
____ Having to do things very slowly to insure correctness
____ Having to check and double-check what you do
____ Difficulty making decisions
____ Your mind going blank
____ Trouble concentrating
____ Having to repeat the same actions such as touching, counting, washing

0____ **TOTAL**

IS

____ Feeling critical of others
____ Feeling shy or uneasy with the opposite sex
____ Your feelings being easily hurt
____ Feeling others do not understand you or are unsympathetic[a]
____ Feeling that people are unfriendly or dislike you
____ Feeling inferior to others
____ Feeling uneasy when people are watching or talking about you
____ Feeling very self-conscious with others
____ Feeling uncomfortable about eating or drinking in public[b]

0____ **TOTAL**

DP

____ Loss of sexual interest or pleasure
____ Feeling low in energy or slowed down
____ Thoughts of ending your life

____ Crying easily
____ Feelings of being trapped or caught
____ Blaming yourself for things
____ Feeling lonely
____ Feeling blue
____ Worrying too much about things
____ Feeling no interest in things
____ Feeling hopeless about the future
____ Feeling everything is an effort
____ Feelings of worthlessness

0____ **TOTAL**

AX

____ Nervousness or shakiness inside
____ Trembling
____ Suddenly scared for no reason[b]
____ Feeling fearful[b]
____ Heart pounding or racing
____ Feeling tense or keyed up
____ Spells of terror or panic[b]
____ Feeling so restless you couldn't sit still
____ The feeling that something bad is going to happen to you
____ Thoughts and images of a frightening nature

0____ **TOTAL**

HS

____ Feeling easily annoyed or irritated
____ Temper outbursts that you could not control
____ Having urges to hurt, injure, or harm someone
____ Having urges to break or smash things

____ Getting into frequent arguments

____ Shouting or throwing things

0____ **TOTAL**

PA

____ Feeling afraid in open spaces or on the streets

____ Feeling afraid to go out of your house alone

____ Feeling afraid to travel on buses, subways or trains

____ Having to avoid certain things, places, or activities because they frighten you

____ Feeling uneasy in crowds, such as shopping or at a movie

____ Feeling nervous when you are left alone

____ Feeling afraid you will faint in public

0____ **TOTAL**

PI

____ Feeling others are to blame for most of your troubles

____ Feeling that most people cannot be trusted

____ Feeling that you are watched or talked about by others[c]

____ Having ideas or beliefs that others do not share

____ Others not giving you proper credit for your achievements

____ Feeling that people will take advantage of you if you let them

0____ **TOTAL**

PS

____ The idea that someone else can control your thoughts

____ Hearing voices that other people do not hear

____ Other people being aware of your private thoughts

____ Having thoughts that are not your own

____ Feeling lonely even when you are with people[d]

____ Having thoughts about sex that bother you a lot

____ The idea that you should be punished for your sins

____ The idea that something serious is wrong with your body[e]

____ Never feeling close to another person

____ The idea that something is wrong with your mind

0___ **TOTAL**

AI

____ Poor appetite

____ Trouble falling asleep

____ Thoughts of death or dying

____ Overeating

____ Awakening in the early morning

____ Sleep that is restless or disturbed

____ Feelings of guilt

0___ **TOTAL**

---

[a]Also loads on the PI dimension
[b]Also loads on the PA dimension
[c]Also loads on the IS dimension
[d]Also loads on the DP dimension
[e]Also loads on the SZ dimension

Please answer each question as completely and accurately as possible. Your information will help me learn about your relationship and help me plan your treatment.

1. What are the things you like most about your relationship?

2. What do you like most about your partner?

3. What are the things you most want to change?

4. How often do you argue? What do you most often argue about?

5. Do your arguments get physical? Verbally abusive? Please detail.

6. Do you feel safe and secure with your partner? Now? In the past? Please detail.

7. In your present relationship, can you ask your partner when you need closeness and comfort? Please detail. Please rate your level of difficulty in doing so (1 extremely easy ---– 10 extremely difficult).

8. Can you think of bonding moments in your relationship when one of you reaches out and the other responds in a way that makes you both feel emotionally connected and secure with each other? Please detail.

9. Who did you go to for comfort when you were young? Could you always count on this person/ these people for comfort? Did this person/ these people ever betray you, or were they unavailable at critical times? What did you learn about comfort and connection from this person/ these people? Please detail.

10. If no one was safe, how did you comfort yourself?

11. Did you ever turn to alcohol, drugs, sex, or material things for comfort?

12. Were there any not previously mentioned traumatic incidents in your growing up, your previous romantic relationships, or otherwise in your life? Use back of page or extra sheet if needed.

13. Were there significant times in your current relationship when you felt your partner was not there for you? Please detail.

14. If it is hard for you to turn to and trust others, to let them close when you really need them, what do you do when life gets too big to handle or when you feel alone?

15. Name two specific things that would make you feel safer and more secure in your present relationship.

16. Anything else about your relationship you wish to share?