Pryor & Associates Counseling and Diagnostic Center



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Couples Counseling Intake Form

Name:				Date:					
Name of Parti	ner:								
Is your partne	er participating	; in therapy:	Yes	No					
Birth Date:	/	/ Age: _		_ Gender:					
Please list any	Please list any children/age:								
Address:									
	Address:(Street and Number)								
(City)		(State)	(Zip)						
Home Phone:			_ May we leav	_ May we leave a message? □ Yes □ No					
Cell/Other Ph	one:		_ May we leav	_ May we leave a message? □ Yes □ No					
E-mail:				May we email you?	□ Yes □ No				
Relationship Status: (check all that apply)									
□ Married together	□ Separated	□ Divorced	□ Dating	□ Cohabitating	□ Living				
☐ Living apart									
Length of time	e in current rel	lationship:							

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern			Freq	uency				
□ No concern			□ No	occurr	ence			
☐ Little concern			□ Occurs rarely□ Occurs sometimes					
□ Moderate concern								
□ Serious concern			□ O o	curs fre	equently	/		
☐ Very serious conce	'n		□ O	curs ne	arly alw	/ays		
What do you hope to	accompli	sh throug	th couns	eling?				
What are your bigges	st strength	ıs as a cou	uple?					
Please rate your curr corresponds with you			-		-	_	er that	
1 2 3	4 5	6	7	8	9	10		
(extremely unhappy)	4 3	O	,	0		remely happy)		
Please make at least relationship regardle					ou could	d personally do	to improve the	

Have you received	prior couples counseling rel	ated to any of the above problems? \square Yes \square No					
If yes, when:		_ Where:					
By whom:		_ Length of treatment:					
Problems treated:							
What was the outcome Very successful	ome (check one)? □ Somewhat successful	□ Stayed the same	□ Somewhat worse				
□ Much worse							
•	your partner been in indivic oncerns that you addressed	_	□ Yes □ No If so, give a				
	ur partner drink alcohol to						
If yes for either, wh	o, how often and what drug	s or alcohol?					
Have either you or the other person?	your partner struck, physica	ally restrained, used viol	ence against or injured				
If yes for either, wh	no, how often and what hap	pened.					

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?									
If yes,	If yes, who?MePartnerBoth of us								
If marı	If married, have either you or your partner consulted with a lawyer about divorce?								
If yes,	If yes, who?MePartnerBoth of us								
Do you	ı percei	ve that	either	you or y	our pa	rtner ha	as with	drawn f	rom the relationship?
If yes, which of you has withdrawn?MePartnerBoth of us									
How fr	equent	ly have	you ha	d sexua	ıl relatio	ons dur	ing the	last mo	onth?times
How enjoyable is your sexual relationship? (Circle one)									
1	2	3	4	5	6	7	8	9	10
(extrer	nely un	pleasan	t)						(extremely pleasant)
How satisfied are you with the frequency of your sexual relations? (Circle one)									
1	2	3	4	5	6	7	8	9	10
(extrer	nely un	satisfie	d)						(extremely satisfied)
What is your current level of stress (overall)? (Circle one)									
1	2	3	4	5	6	7	8	9	10
(no stress)							(high s	tress)	

What	is you	ır curre	nt level	of stre	ss (in th	ne relati	ionship)? (Circle	e one)	
1	2	3	4	5	6	7	8	9	10	
(no st	ress)							(high	n stress)	
being	the m	ost pro	blemat	ic):			-		onship with your partner (1	
Wher	n did y	ou met	/began	dating	?					
Judge	your	relatior	nship ov	er time	e					

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.