THE ART OF
Relationships
GREG DUDZINSKI, MS, LPC

Couples Intake Questionnaire

Name: _____

☐ Male ☐ Female D.O.B. _____ Age: _____

Telephone: _____ Email: _____

Relationship Status:

☐ Married
☐ Living Together
☐ Dating
☐ Divorced
☐ Separated
☐ Other: _____

How Long in Current Relationship: _____

Relationship Dynamic:

☐ Nuclear Family ☐ Step-Family ☐ Other :_____

☐ Biological Children together (how many / ages): _____

☐ Step-Children: Partner 1): how many / ages: _____

Partner 2): how many /ages: _____

Cultural & Ethnic Affiliation

☐ African American ☐ White ☐ Hispanic ☐ Asian ☐ Biracial ☐ Native American

☐ Middle Eastern:_____ ☐ Other _____

Spirituality / Religious Domains:

☐ Catholic ☐ Jewish ☐ Christian / Protestant ☐ Islamic ☐ Jehovah's Witness

☐ Mormon ☐ Hindu ☐ Agnostic ☐ Atheist ☐ Other

Are you active in your faith /religion? YES NO

Primary relationship concerns you'd like to address: _____

_____

_____

Current Stressors: (please check problem area(s) and describe below)

☐ Home / Family ☐ Relationship ☐ Financial ☐ Legal Issues ☐ Loses

☐ Work Related ☐ Multiple Changes ☐ Health ☐ Other

Description of above checked area(s): _____

_____

_____

Have you ever been abused or neglected, or a witness to? Yes No (If yes, please mark below)

☐ Physical ☐ Emotional ☐ Verbal ☐ Sexual ☐ Harassment

☐ Domestic Violence ☐ Other

Description of above checked areas: _____

_____

_____

Prior Counseling or Treatment History (please check appropriate area and describe below)

☐ Prior hospitalizations ☐ Prior substance abuse ☐ Counseling

☐ Current Psychiatrist ☐ Attends Support Group ☐ Medications ☐ Other

Description of above checked area(s): _____

_____

What is the biggest strength in your relationship?

_____

_____

Please tell me your strengths (what you like about yourself):

_____

_____

What has been done to try to improve your relationship challenges?

_____

_____

Your current overall satisfaction with your relationship: (please circle one: 1 = lowest; 10 = great)

1 2 3 4 5 6 7 8 9 10

Are you parenting styles in agreement? (if applies) Yes No

Are there any alcohol or drug usage that creates problems in your relationship? (circle one)

Yes (please explain) _____

No

Any medical conditions that hinder your relationship or sexual relationship? (please explain if yes)

_____

_____

Has there been any physical altercations between you and your partner? (please explain, if yes, type of physical altercations: hitting, slapping, kicking, throwing items. One time occurrence or multiple?)

_____

_____

_____

Has either one of you threatened divorce, or end the relationship? Yes No

According to you, how would you rate your overall sexual satisfaction in your relationship?
(1 being terrible / 10 = fantastic)

1 2 3 4 5 6 7 8 9 10

What would improve your sexual satisfaction? (Check all that apply)

☐ Frequency Increase ☐ Foreplay Improvement ☐ Breaking Routine ☐ Sensuality

☐ Emotional Connection ☐ Sexual Communication ☐ Experimentation ☐ Kissing

How emotionally safe do you feel in your relationship (for example: can talk about any topic if there is an issue)? (1 = not at all safe / 10 = extremely safe)

1 2 3 4 5 6 7 8 9 10

Are you financially on the same page? Yes No

Is there any other information that this questionnaire may have missed that you feel is important?

YES NO

If yes above, please describe: _____

_____

Signature of Client: _____ **Date:** _____

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