

OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC

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COUPLES INTAKE ASSESSMENT

Name: _____ Date: _____

Name of Partner: _____

Relationship Status: (check all that apply)

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Married | <input type="checkbox"/> Dating |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Living together |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Living apart |

Length of time in current relationship: _____

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

- No concern
- Little concern
- Moderate concern
- Serious concern
- Very serious concern

Frequency

- No occurrence
- Occurs rarely
- Occurs sometimes
- Occurs frequently
- Occurs nearly always

What do you hope to accomplish through counseling? _____

What have you already done to deal with the difficulties? _____

What are your biggest strengths as a couple? _____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship. 1-----2-----3-----4-----5-----6-----7-----8-----9-----10

extremely happy

extremely unhappy

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does. _____

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Have you received prior couples counseling related to any of the above problems? Yes No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

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? _____

Have 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? If yes, who? ___ Me ___ Partner ___ Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

If yes, who? ___ Me ___ Partner ___ Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

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? (Circle one) 1----2----3----4----5----6---7----8---9---10

extremely pleasant

extremely unpleasant

How satisfied are you with the frequency of your sexual relations? (Circle one)

1----2----3----4----5----6---7----8---9---10

extremely satisfied

extremely unsatisfied

What is your current level of stress (overall)? (Circle one)

1----2----3----4----5----6---7----8---9---10

No Stress

extremely stressed

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What is your current level of stress (in the relationship)? (Circle one)

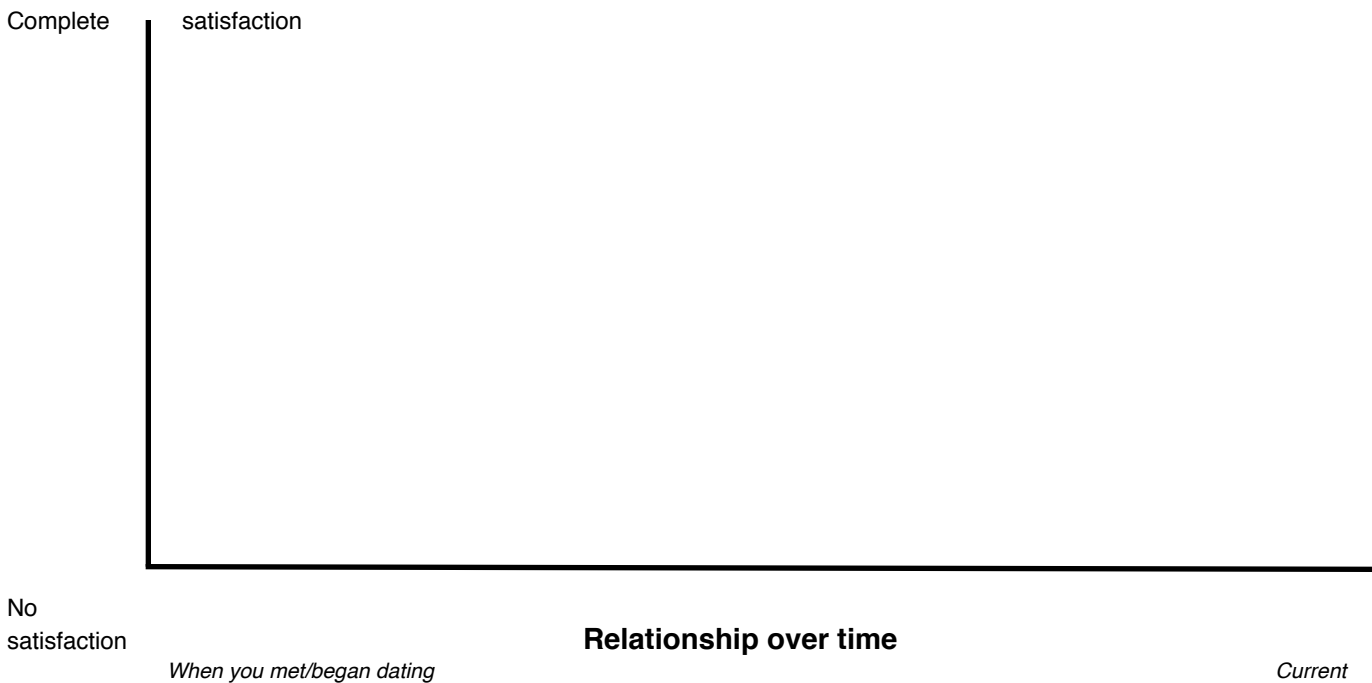
1----2----3----4----5----6---7---8---9---10
No Stress extremely stressed

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

(1 being the most problematic):

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).



Thank you for completing this. Please bring this with you during your next appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.