

**Couple Intake Form**

Wendy E. Smith, MA, LMHCA  
18 W. Mercer St., Seattle, WA 98119  
(206) 965-8749  
[www.wendysmithcounseling.com](http://www.wendysmithcounseling.com)

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

Religious affiliation, if any: \_\_\_\_\_

Ethnic/ racial/ national/ indigenous heritage: \_\_\_\_\_

Other way you identify yourself that is important to you: \_\_\_\_\_

Have you ever received counseling, psychiatric, or drug or alcohol treatment before? Y\_\_ N\_\_  
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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SCL - 90RA

Name \_\_\_\_\_

Date \_\_\_\_\_

Below is a list of problems and complaints people sometimes have. Please reach 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
- \_\_\_ **Total**

#### **OC**

- \_\_\_ Repeated unpleasant thoughts 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 ensure 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
  - \_\_\_ **Total**
-

**IS**

- \_\_\_ Feeling critical of others
- \_\_\_ Feeling shy or uneasy with the opposite sex
- \_\_\_ Your feelings easily being hurt
- \_\_\_ Feeling others do not understand you or are unsympathetic<sup>a</sup>
- \_\_\_ 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<sup>b</sup>
- \_\_\_ **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
- \_\_\_ **Total**

**AX**

- \_\_\_ Nervousness or shakiness inside
- \_\_\_ Trembling
- \_\_\_ Suddenly scared for no reason<sup>b</sup>
- \_\_\_ Feeling fearful<sup>b</sup>
- \_\_\_ Heart pounding or racing
- \_\_\_ Feeling tense or keyed up
- \_\_\_ Spells of terror or panic<sup>b</sup>
- \_\_\_ 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
- \_\_\_ **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
  - \_\_\_ **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, 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  
 **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<sup>c</sup>  
 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  
 **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<sup>d</sup>  
 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<sup>e</sup>  
 Never feeling close to another person  
 The idea that something is wrong with your mind  
 **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  
 **Total**

<sup>a</sup> Also loads on the PI dimension<sup>b</sup> Also loads on the PA dimension<sup>c</sup> Also loads on the IS dimension<sup>d</sup> Also loads on the DP dimension<sup>e</sup> 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?



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. Have there been any particularly traumatic incidents in your previous romantic relationships? Please detail.

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?

Client signature \_\_\_\_\_ Date \_\_\_\_\_

