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COUPLES THERAPY INITIAL INTAKE FORM

Name:		Date:					
Address:	Phone:	(OK to leave message? Yes / No)					
Name of Partner:							
Relationship Status: (check all	that apply)						
□ Married		□ Cohabitating					
□ Separated		□ Living together					
□ Divorced		□ Living apart					
□ Dating							
Length of time in current rela	ntionship:						
As you think about the prima your overall level of concern a		re, how would you rate its frequency and					
Concern		Frequency					
□ No concern		□ No occurrence					
□ Little concern		□ Occurs rarely					
□ Moderate concern		□ Occurs sometimes					
□ Serious concern		□ Occurs frequently					
□ Very serious concern		□ Occurs nearly always					
What do you hope to accompli	sh through counseling?						
What have you already done	to deal with the difficulties?						
What are your biggest streng	ths as a couple?						

(extremely un	happy)	3	4	5	6	7	8	9	10 (extremely happy)
ease make at leas ationship regard					you cou	ıld pers	sonally	do to ii	nprove the
ve you received	prior cou	ples cou	nseling 1	related	to any (of the a	bove pr	oblems	s? □ Yes □ No
If yes, when	:					Where:_			
By whom: _					I	Length o	of treatn	nent:	
Problems tre	eated:								
hat was the outc	ome (checl	c one)?							
				C 1 . C.	oved the	same i	¬ Somey	what wo	orga = Much worga
□ Very succ	essful 🗆 S	omewhat	success	ful 🗆 Sta	ayeu me	barre :			orse Much worse
□ Very succ eve either you or so, give a brief su	your part	ner been	in <i>indi</i>	vidual d	counseli				

	ither you or y er person?	our part	ner stri	ick, phy	sically r	estrai	ned, used	viole	nce ag	ainst or injured
Yes 🗆 N	No 🗆 If yes t	for either,	who, he	ow often	and wha	at happ	ened.			
	her of you th problems?	reatened	to sepa	rate or d	livorce ((if ma	rried) as	a resu	lt of th	e current relationshi
	Yes □ No □	If yes, v	vho?	_Me	P	artner	B	oth of	us	
If marr	ried, have eitl	ner you o	r your j	partner (consulte	ed witl	n a lawye	r abou	ıt divo	rce?
	Yes □ No □	If yes, v	vho?	_Me	P	artner	B	oth of	us	
Do vou	perceive tha	t either v	ou or v	our part	ner has	withd	rawn fro	m the	relatio	onship? Yes □ No □
, , , , , , , , , , , , , , , , , , ,	If yes, which			-						-
How fr	equently hav	e you had	l sexual	relation	ıs durin	g the l	ast mont	h?		times
How en	ijoyable is yo	ur sexual	relatio	nship? (Circle o	ne)				
	1 (extremely unp	2 leasant)	3	4	5	6	7	8	9	10 (extremely pleasant)
How sa	tisfied are yo	ou with th	e frequ	ency of	your sex	kual ro	elations?	(Circle	e one)	
	1 (extremely unsa		3	4	5	6	7	8	9	10 (extremely satisfied)
What is	s your curren	ıt level of	stress (overall)	? (Circle	e one)				
	(no stress)	2	3	4	5	6	7	8	9	10 (high stress)
What is	s your curren	t level of	stress (in the re	elationsl	hip)? (Circle on	e)		
	(no stress)	2	3	4	5	6	7	8	9	10 (high stress)

Rank ord most prob	er the top three concernolematic):	s that you have in	ı your relationshi	p with your partne	r (1 being the
	1				
Lastly, plomet your	ease draw a graph indic partner. Note pivotal/sig ed).	ating your level o	f relationship sat i your relationship (isfaction beginning e.g., one of you mov	with when you ed out, one of
Complete satis	faction				
	Auton (
No satisfaction		Relatio	nship over time	;	
VVI	hen youmet/began dating				Current

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.