Aspiring Hearts Counseling, PLLC
Mending Hearts... Changing Lives.

Couples Intake Questionnaire

(This entire document should be completed twice. Once by each party.)

Name:			Date:
Birth Date:	Age:	Soc Sec Num:	
Address:			
Home Phone:	Ok to leave messages? ☐ Yes ☐ No		
Cell Phone:	Ok to leave messages? ☐ Yes ☐ No		
Work Phone:	Ok to leave messages? ☐ Yes ☐ No		
Email:			
Spouse/Significant Other's Name:			

Reasons for Services/Relationship Issues (Check all that apply)

☐ Improve Communication	☐ Frequent Arguing	☐ Physical Aggression	☐ Dishonesty
☐ Trust Issues	☐ Cheating/Affair(s)	☐ Sexual Issues	☐ Inability to Compromise
☐ Compatibility Issues	☐ Others:		

Individual Problems/Symptoms (Check all that apply)

☐ Depression / Sadness	☐ Anger / Rage	☐ Anxiety / Worry	☐ Career Counseling	☐ Poor Memory
☐ Suicidal Thoughts	☐ Excessive Guilt	☐ Panic Attacks	☐ Crying Spells	☐ Fears / Phobias
☐ Suicidal Attempt(s)	☐ Addictive Behaviors	☐ Mood Swings	☐ Poor Concentration	☐ Sleeping Too Much
☐ Withdrawal/Isolation	☐ Sleeping Problems	☐ Sexual Issues	☐ Change in Appetite	☐ Low Energy
☐ Mania / Happiness	☐ Feeling Stressed	☐ Reckless	☐ Excessive Spending	☐ Unreasonable Avoidance
☐ Nightmares	☐ Confusion	☐ Paranoia	☐ Overwhelmed	☐ Repetitive Behaviors
☐ Hyperactive	☐ Grief / Loss	☐ Hallucinations	☐ Homicidal Thoughts	☐ Obsessive Thoughts
☐ Sleep Problems	☐ Uncaring Attitude	☐ Loss of Interest	☐ Bowel Movement Change	☐ Dangerous Behaviors
☐ Shortness of Breath	☐ Heart Palpitations	☐ Muscle Tension	☐ Obsessions/Compulsions	☐ Irritable
☐ Others:				

Other stressors or problems you have (Check all that apply)

☐ Legal Issues	☐ Family Problems	☐ Divorce	☐ Parenting
☐ Difficulty Coping	☐ Social Problems	☐ Recent Death, Loss, or Change	☐ Financial Problems
☐ Difficulty with Children	☐ Job/Work Problems	☐ Home/Housing Problems	☐ Health Problems
☐ Educational/School Problems	☐ Friend Problems	☐ Transportation Problems	☐ Self-Esteem Issues
☐ Others:			

Have you experienced anything traumatic? (check all that apply) ☐ None

☐ Physical Abuse	☐ Sexual Abuse	☐ Rape	☐ Domestic Violence	☐ Traumatic Injury
☐ Traumatic Accident	☐ Assault	☐ Robbery	☐ Death or Loss	☐ Witnessed Trauma
☐ Other:				

16 W. Martin St., Suite 401 ♥ Raleigh, NC 27601 ♥ 919-538-3458 ♥ Fax: 1-888-325-6160 ♥ info@aspiringhearts.com
www.aspiringhearts.com

Do you use tobacco? ☐ Currently ☐ Past ☐ None	Do you drink alcohol? ☐ Often ☐ Regularly ☐ Sometimes ☐ Rarely ☐ No
Do you use non-prescribed drugs? ☐ Regularly ☐ Socially ☐ Occasionally ☐ Rarely ☐ Never ☐ Past Use	

Have you ever received individual counseling? ☐ Yes ☐ No	Have you been a patient of a mental hospital within the past year? ☐ Yes ☐ No
If Yes, what agencies?	
Do you have a psychiatrist? ☐ Yes ☐ No Name/Agency:	

Physician Name/Agency:	Phone:
Date of last physical:	Allergies:
Medical Problems:	

Do you take any prescription or regular over the counter medications? ☐ Yes ☐ No (If yes, list below)

Medication	Dosage	Frequency	Reason for Medication

Medication concerns / Notable side effects:

Highest level of education completed:

☐ Some High School ☐ High School Diploma ☐ GED ☐ Some College/Tech School ☐ Diploma or Certification program

☐ Associates Degree ☐ Bachelor’s Degree ☐ Master’s Degree ☐ All But Dissertation ☐ Doctorate ☐ Other

If you attended post-secondary school or obtained a diploma or certification, what was/were your major(s) or area(s) you reached your achievement(s):

Are you currently in school? ☐ Yes ☐ No If yes, What school:

What is your employment status:

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Not Working by Choice ☐ Disabled ☐ Retired

Are you seeking a new job or new career? ☐ Yes ☐ No ☐ Unsure	Military Status? ☐ None ☐ Active Duty ☐ Veteran
What is your current or last job/position:	

Number of Children with Current Partner:	Number of Children with Other(s):

What is your Relationship History: (Check all that apply)

☐ Divorced ☐ Multiple Divorces ☐ Death of Previous Spouse/Sig. Other

☐ Difficulty Finding Relationships ☐ Difficulty Maintaining Relationships ☐ Bi-sexual/Same Sex Relationships

☐ Difficulty with Commitment ☐ Past Domestic Violence ☐ Previous Significant Relationship(s)

☐ No Significant Prior Relationships ☐ Regular One Night Stands In the Past ☐ Polyamory

☐ Other:

To which cultural or ethnic group, if any, do you belong?
Is there any cultural or ethnic info we should be aware of?
How religious or spiritual are you? ☐ A lot ☐ Moderately ☐ A Little ☐ Not at All
Which religious/spiritual group, if any, do you belong?

Describe your social life: (Check all that apply)

☐ I am very social	☐ I am moderately social	☐ I prefer to not be social
☐ I have a lot of friends	☐ I have a few close friends	☐ I have very little or no friends
☐ I have trouble making friends	☐ I would like to make more friends	☐ I am not a people person
☐ I used to be social but now not as much	☐ I get out a lot	☐ I would like to get out more
☐ I avoid crowds	☐ I avoid social situations	☐ Other

What are your hobbies, or things you like to do:
What are your strengths, or things you are good at:
What do you like about yourself or are proud of yourself for:

Emergency Contact:	Relationship:
Cell Phone:	Phone:
Address:	
Initial: ________	I give Aspiring Hearts Counseling permission to contact the above listed Emergency Contact in the event of an emergency. I understand Aspiring Hearts Counseling may have to release confidential information to the Emergency Contact.

Please Complete the following questions concerning your current relationship.

How long have you been a couple?	How long have you known each other?
Current Relationship status: ☐ Married ☐ Domestic Partnership ☐ Engaged ☐ Divorced ☐ Separated ☐ Dating ☐ Living Together ☐ Living Separately	
As you think about your primary reason(s) for counseling, how would you rate its frequency and your current level of concern?	
Frequency: ☐ No Occurrence ☐ Occurs Rarely ☐ Occurs Sometimes ☐ Occurs Frequently ☐ Occurs Nearly Always	
Concern: ☐ No Concern ☐ Little Concern ☐ Moderate Concern ☐ Serious Concern ☐ Very Serious Concern	
What do you hope to accomplish through counseling?	
What have you done already to deal with the difficulties?	
Have you had couples counseling in the past? ☐ Yes ☐ No	If yes, how many times?
If yes, when?	If yes, how long was treatment?
If yes, what was the outcome of treatment? ☐ Successful ☐ Somewhat Successful ☐ Stayed the Same ☐ Somewhat Worse ☐ Much Worse	

What are your biggest strengths as a couple?

Please rate your current happiness in the relationship:

(Extremely Unhappy) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Extremely Happy)

List any significant changes in the relationship or within the life of you or your partner:

Please make at least one suggestion as to something you can personally do to improve the relationship regardless of your partner:

Have either you or your partner struck, physically restrained, used violence against, or injured the other person? ☐ Yes ☐ No

If yes, explain (who, how often, what happened)

Have either of you threatened to separate/divorce/break-up over as a result of the current problems in the relationship?

☐ No, Neither of Us ☐ Yes, I Have ☐ Yes, My Partner Has ☐ Yes, Both of Us

If married, have either you or your partner consulted with an attorney about divorce?

☐ Not Married ☐ No, Neither of Us ☐ Yes, I Have ☐ Yes, My Partner Has ☐ Yes, Both of Us

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

☐ No, Neither of Us ☐ Yes, I Have ☐ Yes, My Partner Has ☐ Yes, Both of Us

How many times have you had sexual relations in last 30 days?

Please rate how much you enjoy your sexual relationship:

(Extremely Unpleasant) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Extremely Pleasant)

Please rate your satisfaction with the frequency of your sexual relations:

(Extremely Unsatisfied) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Extremely Satisfied)

Please rank your overall stress level:

(No Stress) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Extremely High Stress)

Please rank your stress level within the relationship:

(No Stress) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Extremely High Stress)

Rank the top 3 concerns in the relationship with your partner with 1 being the most problematic:

1.

2.

3.

Signature:	Date: