



Oak Creek Relational Counseling Center

## Couples intake questionnaire

**Please answer the following questions the best you can**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**What do you feel are the biggest problems in your**

**Marriage?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**When do you feel the problems**

**started?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**What are some things about your partner that gets on your nerves?**

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**Do You Trust your partner? If no, then**

**why?** \_\_\_\_\_

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**Do you feel safe at home with your partner? If no**

**why?** \_\_\_\_\_

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**Do you feel accepted by your partner? If no, then**

**why?** \_\_\_\_\_



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**Are you sexually satisfied? If not, what could make it better?**

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**Why did you decide to come to couples counseling?**

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**What do you think you can do to make the marriage better?**

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**Where do you see your relationship in "X" Years?**

**1 YEAR**

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**5 YEARS**

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**10 YEARS**

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**Do you feel loved and appreciated by your partner? Why or why not?** \_\_\_\_\_

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**What do you love most about your partner?**

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**What are your expectations of counseling?**

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**What are the reasons you want to work things out?** \_\_\_\_\_

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**Are there any past conflicts that need resolving?**

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**Are you willing to change to make improvements?**

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**Your Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_