KINGSBURY COUNSELING | Josh Kingsbury, Ph.D.
LICENSED PSYCHOLOGIST

251 Woodford Street
Portland, ME 04103
(207) 773-2828 x107
josh@kingsburycounseling.com
www.kingsburycounseling.com

Couples Counseling Initial Intake Form

Please note that while you will be asked to talk about your answers in session, your partner will not be shown this form.

Name			Intake Date			
Date of Birth	Age	F	M	MtF	FtM	
Preferred Pronouns			Relationship Status			
Street Address			City/State/Zip			
Cell Phone			Okay to leave message?		Y	N
Home Phone			Okay to leave message?		Y	N
Work Phone			Okay to leave message?		Y	N
Email			Okay to contact via email?		Y	N
Preferred method(s) of contact						
Cell	Home	Work	Email	Text		
Ethnic/Racial Identity			Sexual Orientation			
Occupation			Employer/School			
Spiritual Orientation			Referred by			

Initials (of Individual, couple or family) ________________

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Relationship Status: (check all that apply)

☐ Married ☐ Living Together ☐ Divorced

☐ Separated ☐ Living Apart ☐ Dating

Length of time in current relationship? ________________

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 unhappy) (extremely happy)

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

____

____

____

Have you received prior couples counseling related to any of the above problems?

____

____

____

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Have either of you been in individual counseling before? ☐ Yes ☐ No

____
____
____

If so, please give a brief summary of the concerns you addressed.

____
____
____

Do either you or your partner drink alcohol or take drugs to intoxication? ☐ Yes ☐ No

If yes for either, who, how often, and what drugs or alcohol?

____
____
____

Do you ever wish your partner would cut back on his/her drinking or drug use?

☐ Yes ☐ No ☐ N/A

Have either your or your partner stuck, physically restrained, used violence against or injured the other person?

☐ Yes ☐ No If yes, 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?

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

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

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

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Do you perceive that either you or your partner has withdrawn from the relationship?

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10

(extremely unpleasant) (extremely pleasant)

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

1 2 3 4 5 6 7 8 9 10

(extremely unsatisfied) (extremely satisfied)

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

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

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

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

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Couple Satisfaction Checklist

Place a check in the box to the right of each relationship category that best describes how satisfied you feel.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check 3 areas you most want to change
Degree of Closeness, Openness, Confiding, Sharing and Comforting							
Expression of Affection and Caring							
Satisfaction with Sexual Intimacy							
Handling Conflicts and Arguments							
Expression of Anger, Criticism or Blame							
Handling Family Finances							
Handling of Parenting Issues							
Handling of Household Tasks							
Common Interests and Social Life							
Degree of Respect and Admiration for Your Partner							
Satisfaction with Your Role in the Relationship							
Satisfaction with Your Partner's Role in the Relationship							
Overall Satisfaction with Your Relationship							

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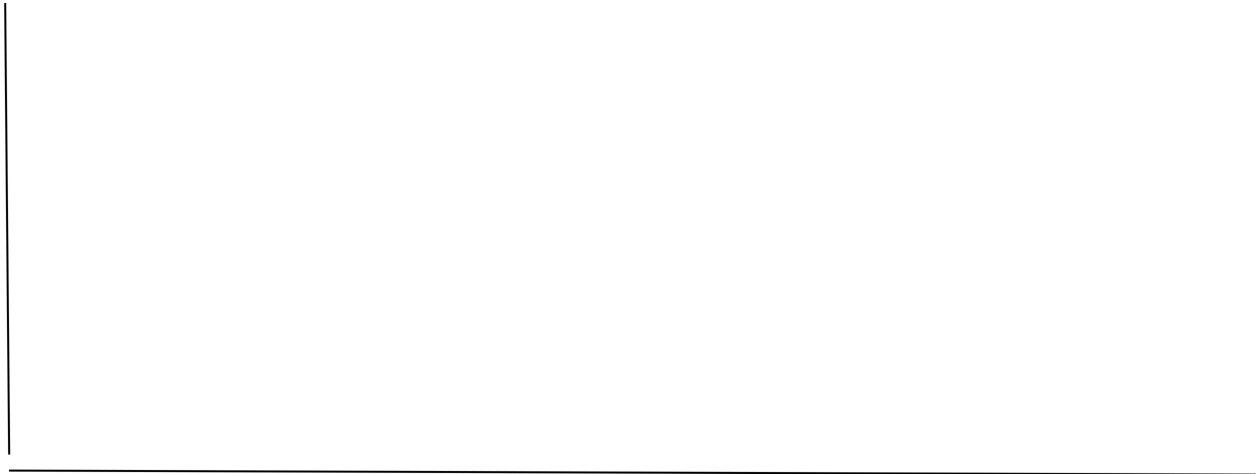
Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note *pivotal/significant events* in your relationship (e.g., one of you moved out, one of you cheated).

Complete satisfaction



No satisfaction

Relationship over time

When you met/began dating ***Current***

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Authorization for Release/Request of Confidential Information

(Release for EMERGENCY CONTACT)

Permission is hereby given to Josh Kingsbury, Ph.D. to release and/or exchange information for professional use from the records of:

Client Name ____

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

The type of information is limited to (check at least one):

[ ] any and all information | [ ] psychological evaluation(s)

[ ] discharge summary/report | [ ] confirmation of services

[ ] treatment summary | [ ] drug and alcohol issues

[ ] intake summary/report | [✖] other (Emergency Contact)

[ ] with the following exceptions____

The information should be released to, received from, and/or exchanged with:

____

Name

____

Address

Telephone and Fax ____

This authorization shall remain in effect until. ________________________

I understand that I may revoke this consent at any time by notifying my therapist, Josh Kingsbury, Ph.D., in writing. I also hereby release Josh Kingsbury, Ph.D., from any liability in connection with the release of the above information.

____

Client Full Name   Date of Birth

____

Address

____

Client Signature   Date

____

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Authorization for Release/Request of Confidential Information

(Release for PRIMARY CARE PROVIDER)

Permission is hereby given to Josh Kingsbury, Ph.D. to release and/or exchange information for professional use from the records of:

Client Name ____

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

The type of information is limited to (check at least one):

[✖] any and all information | [ ] psychological evaluation(s)

[ ] discharge summary/report | [ ] confirmation of services

[ ] treatment summary | [ ] drug and alcohol issues

[ ] intake summary/report | [ ] other

[ ] with the following exceptions____

The information should be released to, received from, and/or exchanged with:

____

Name

____

Address

Telephone and Fax ____

This authorization shall remain in effect until. ________________________

I understand that I may revoke this consent at any time by notifying my therapist, Josh Kingsbury, Ph.D., in writing. I also hereby release Josh Kingsbury, Ph.D., from any liability in connection with the release of the above information.

____

Client Full Name   Date of Birth

____

Address

____

Client Signature   Date

____

Josh Kingsbury, Ph.D.

Initials (of Individual, couple or family) _________________