

COUPLES QUESTIONNAIRE

Please fill this form out completely. If you are not sure how to answer a question, leave it blank and discuss it with your therapist. Write N/A for those that don't apply.

Client Information:

Name: _____ D.O.B. _____

Occupation: _____ Education: _____

*Who were you referred by? _____

Current Relationship Status: (Please check all that apply)

_____ living together _____ dating _____ engaged _____ married _____ separated

_____ divorced _____ monogamous _____ open _____ polyamorous _____ other: _____

Relationship History:

How long have you known your partner?

How long have you been in a relationship with your partner?

How long have you been experiencing relationship difficulties with your partner?

Have you ever been married in the past? If so, were you divorced or widowed?

Current Home Environment:

Do you have children and/or stepchildren? If so, how many and what are their living arrangements?

Do you currently have any relatives or friends living in the home with you? If so, who?

Goals for Attending Counseling:

I am attending counseling because: (Please check all that apply)

_____ It is important to my partner

_____ It is important to me

_____ Family / friends encouraged my partner and I

_____ The next step is separation

_____ I want to improve my relationship with my partner

_____ The next step is divorce

_____ Other: _____

Desired Outcomes for Self: (Please check all that apply)

_____ Get more of my needs met in my relationship

_____ Be more patient with my partner

_____ Communicate effectively with my partner

_____ Be more supportive of my partner

- | | |
|--|--|
| <input type="checkbox"/> Express my anger without hurting my partner | <input type="checkbox"/> Feel more secure in my relationship |
| <input type="checkbox"/> Feel better about myself | <input type="checkbox"/> Be less critical of my partner |
| <input type="checkbox"/> Decrease feelings of jealousy | <input type="checkbox"/> Other: _____ |

Desired Outcomes for Couple: *(Please check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Participate in new activities as a couple | <input type="checkbox"/> Laugh and enjoy each other as a couple |
| <input type="checkbox"/> Take an interest in each other's hobbies | <input type="checkbox"/> Show affection with each other |
| <input type="checkbox"/> Verbalize thoughts & feelings effectively | <input type="checkbox"/> Spend more time together |
| <input type="checkbox"/> Learn how to disagree in a calm way | <input type="checkbox"/> Be honest with each other about our feelings |
| <input type="checkbox"/> Improve sexual relationship | <input type="checkbox"/> Increase the level of trust in our relationship |
| <input type="checkbox"/> Improve parenting of children | <input type="checkbox"/> Work together as a team |
| <input type="checkbox"/> Other: _____ | |

Areas of Concern: *(Please check all that apply)*

- Abuse / Domestic Violence (_____ currently or _____ in the past) _____ Children
- Communication styles and/or patterns (verbal/non-verbal)
- Critical Partner
- Difference in Work Schedule
- Elder Care Concerns / Stressors
- Expression of Love / Affection
- Extended Family / In-Law Relationships
- Extramarital Relations / Affair / Infidelity
- Financial Stressors that Lead to Relationship Conflict
- Household Responsibility / Roles
- Infertility
- Lack of Trust
- Lack of Support from Partner for Career, Interests, Hobbies
- Pregnancy Loss
- Intimacy / Sexual Concerns
- Medical Diagnosis of Partner or Self
- Medical Diagnosis of Child
- Mental Health Concerns
- Physical Care of Partner
- Previous Marriage / Step-Child(ren) Relationship Concerns
- Religion / Spirituality / Culture
- Recent Legal Problems
- Recent Loss of Loved One or Friend
- Substance Use
- Suicidal Thoughts
- Homicidal Thoughts
- Time Spent Together
- Work / Career Concerns
- Other (Please list): _____

How has your life been impacted by your relational problems? *(Please check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Sleeping problem | <input type="checkbox"/> Increased fighting with friends or family |
| <input type="checkbox"/> Eating habits have changed | <input type="checkbox"/> Financial trouble |
| <input type="checkbox"/> Affecting my job | <input type="checkbox"/> Less time with family and friends |
| <input type="checkbox"/> Feeling irritable | <input type="checkbox"/> Feeling sad |
| <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Feeling Lonely |
| <input type="checkbox"/> Feeling angry | <input type="checkbox"/> Low Self-Esteem |
| <input type="checkbox"/> Difficulty parenting | <input type="checkbox"/> Other: _____ |

Have there been any major changes in your life in the past 6 months? *(Check all that apply)*

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Death of a friend or family | <input type="checkbox"/> Loss of job |
|--|--------------------------------------|

_____ Move
_____ Birth of a child
_____ Pregnancy loss
_____ Friend or family moved
_____ Diagnosis of medical condition
_____ Other: _____

_____ Change in job
_____ Pregnancy
_____ Adoption
_____ Went back to school
_____ Friend or family moved into home

Have you ever attended couples counseling in the past? If so, when and for what concerns?

Have you ever sought counseling for yourself? If so, when and for what concerns?

Have you ever been diagnosed with a mental or emotional disorder? If so, when and what? Are you currently on any medications? If so, please list the medications and the conditions they treat:

Is there any other information that will be helpful for us to know about you and / or your relationship?

The information contained herein is complete and truthful to the best of my/our ability.

Client Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____