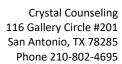


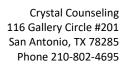


Client's Name:	Date:
Gender:FM Date of Birth://	Age:
Phone (home): (work):	(cell):
Okay to leave messages \Box Voice \Box Text On what number may we leave \Box Work	eave a confidential message: □Home □Cell
Email Address	
Emergency Contact Person:	Phone:
Relationship to client:	
What are your primary concerns about the relationship?	
Relationship Status: (check all that apply)	
☐ Married ☐ Living Together ☐ Divorced ☐ Separated ☐	
How long have you and your partner been together?	
Please list previous marriages/significant relationships (Partner's Na Length of Relationship, Reason for Ending Relationship)	ame, # of children from Marriage/Relationship,
Please list all children: Please add Name, M/F, Age, where living.	
What do you hope to accomplish through counseling?	
What have you already done to deal with the difficulties?	





What initially attracted you to yo	our partner?		
What are your biggest strengths	as a couple?		
How comfortable are you if your	partner spends free time a	way from you?	
Do you have relationships with o	ther people that create cor	nflict with yourpartner, and if so,	why?
Please rate your current level of	relationship happiness by c	ircling the number that correspon	nds with your current
feelings about the relationship. ($\begin{array}{cccccccccccccccccccccccccccccccccccc$	1 = extremely unhappy; 10 5 6 7 8 stion as to something you co		
Have you received prior couples If yes, With whom:	counseling related to any o	f the above problems? □ Yes □	No
Where:Outcome:	Length of treatment		
Have either you been in individu If so, give a brief summary of cor	_	s 🗆 No	
Check all mental/behavioral cor Anger management Eating disorder Sleeping Disturbance Self-Esteem	ncerns/issues Anxiety Parenting Suicidal Ideations Alcohol/Drugs	Self-Harming Behaviors Stress Depression/Sadness Inattentiveness	DepressionFear/phobiasHyperactivityGender Identity

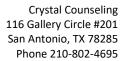




Marital Conflict Infidelity		Chronic Pain		
Abuse (Physcial, Mental, Sexual) Other				
Have you been hospitalized for any Mental Illness?		w many times? _		
When?				
Is this negatively impacting your life:				
Have you had suicidal thoughts recently?frequently Have you had them in the past?frequently	sometimes sometimes	rarely rarely	never never	
Have you ever intentionally inflicted any harm upon yourself?	Yes	No	Unsure	
Client Medical / Physical Health	5 . 1 .	D		
AbortionAsthmaBlackouts Hives MeningitisMiscarriage		Dizziness		nple
NivesMiscarriage Severe head injuryThyroid disorder				
List any current health concerns:				
When was your last medical appointment with you Did you discuss your current symptoms:Yes		<u></u>		
What were the results of the appointment?	_ 110			
Diagon about if the one have been any recent about	a in the fallernin			
Please check if there have been any recent change Sleep patterns Physi			el Atten	tion level
BehaviorWeight Gene				
Describe the changes in areas checked above:				
Medications (Please list all medications)				
Currently prescribed medications Dose	Frequency	Date Started	Purpose	Side Effects
				□No □Yes
				□No □Yes
				□No □Yes □No □Yes
				□No □Yes
				

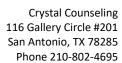


List an	y medi	cation	allergi	es:						
Do eitl	ner you	ı or yo	ur part	ner drin	k alcoh	ol or tal	ke drug	s to into	xicatio	n? □ Yes □ No
If yes ,	for eit	her, w	ho, hov	v often	and wh	at drug	s or alco	ohol?		
Do you	ı ever v	wish yo	our par	tner wo	uld cut	back or	n his/he	r drinki	ng or di	rug use? □ Yes □ No □ N/A
	-		-		-	hysically nat happ			ed viol	ence against or injured the other person?
Are the	ere any	pend	ing lega	al issues	? Child	custody	y? Restr	raining o	orders?	
		-			-	or divo	-	narried)	as a re	sult of the current relationship problems? \Box
If mari	ied, ha	ıve eitl	ner you	or you	r partne	er consu	ılted wi	th a law	yer abo	out divorce?
□ Yes	□ No	If yes,	who? l	⊐ Me □	□ Partn	er 🗆 B	Both of	us		
Do you	ı perce	ive tha	at eithe	r you or	your p	artner h	nas with	ndrawn	from th	ne relationship?
□ Yes	□ No	If yes,	who?	□ Me [□ Partn	er 🗆 B	oth of u	ıs		
What i	s your	currer	it level	of stres	s (overa	all)? (Cir	cle one	e)(1 = nc	stress;	; 10 = high stress)
1	-	2	3	4	5	6	7	8	9	10
What i	s your	currer	it level	of stres	s (in the	e relatio	nship)	(1 = no	stress;	10 = high stress)
1	-	2	3	4	5	6	7	8	9	10
How a	ware o	r in to	uch wit	h your e	emotior	ns are yo	ou (1 =	not at a	II; 10 =	extremely)
1		2	3	4	5	6	7	8	9	10





How open are you in expressing your innermost feelings, desires and thoughts to your partner (1 = not at all; 10 = extremely) 10 1 2 Family History (Please check any past, present, or impending special problems in your family) deaths ___divorce _frequent relocations ___serious illness _debilitating injuries/disabilities _alcohol/drug abuse ___psychiatric disorder _physical/sexual abuse legal problem __financial crisis/unemployment ___attempted/completed suicide _eating disorders _other _ Please specify family member(s), with special problems, and approximate year of occurrence (e.g. mother, serious illness, 1998, etc.) **Cultural Background:** What is your **ethic identity**? African/African American ____Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese ___Latino/ Hispanic/ Mexican-American/ Puerto Rican East Indian/Pakistani Native American/ Alaskan Native Middle Eastern ____White/Caucasian Polynesian/Micronesian Other (specify) How much do you identify with your ethnic heritage? (Check one): ___Somewhat ___Not at all ___A little Moderately **Religious/Spiritual Background:** Do you consider yourself a religious person?___Yes ____No or spiritual person? ____Yes ____No Faith: Group/Denomination in which you were raised: ____ Current Congregation/Church: How active are you? ____Inactive ____ Slightly Moderate Very **Academic Background:** Where did you attend high school? Did you attend college/professional school? When, where, degree earned? Any plans to further your education? _____ If so, when and what?





Please list any additional information that you believe will be helpful for your therapist to know.						
For Staff Use						
Therapist's comments:						
Therapist's signature/credentials:	Date:					
Supervisor's signature/credentials:	Date:					

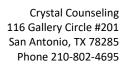


Name	Date

Couple Satisfaction Checklist

Place a check (/) in the box to the right of each relationship category that best describes how satisfied you feel today about your relationship.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check (√) 3 areas you want most to change
1. Degree of closeness, confiding, sharing and comforting.							3
2. Expression of affection and caring.							
3. Satisfaction with sexual intimacy.							
4. Handling conflicts and arguments.							
5. Expression of anger, criticism or blame.							
6. Handling family finances.							
7. Handling of parenting issues							
8. Handling of Household Tasks							
9. Common interests and social life							
10. Degree of respect and admiration for Your partner							
11. Satisfaction with your role in the relationship							
12. Satisfaction with your partner's role in the relationship							





13. Overall				
satisfaction with				
Your relationship				