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Fax: (503) 566-9864 or (503) 364-5121

COUPLES THERAPY INTAKE QUESTIONNAIRE

(*EACH PARTNER NEEDS TO COMPLETE THIS FORM SEPARATELY)*

NAME: ____

What brought you into therapy at this time (i.e., what events or conversations prompted the action)?

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What do you wish to change or accomplish as a result of therapy? (Describe 3 improvements you hope to observe in your relationship by the end of treatment).

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Provide a brief timeline of your relationship (including important dates or events) and explain in a sentence or two what makes this relationship is meaningful or special to you (i.e., what do you treasure or appreciate most about your history together?).

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What attempts have you made to address concerns with your partner? How does your partner respond & would have you observed any of success at all with these attempts or strategies?

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Have you been in therapy before? Yes No

If yes, please note the when, name of clinician/agency, primary issues addressed, & indicate whether it was helpful.

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Reflecting on the last 6 months, please circle all that apply:

Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	Mood Swings
Irritable and/or short temper	Decreased need for sleep (only need 3-4 hrs)
Significant change in weight	Feel more talkative than usual
Low energy level/fatigue	Excessive spending/shopping
Feeling excessive guilt or shame	Excessive gambling
Unable to relax	Easily distracted by unimportant things
Lack of appetite/increased appetite	Take too many risks
Loss of interest in activities/hobbies	Troubling thoughts about the past
Feeling hopeless	Nightmares
Feeling worthless	Exaggerated startle response
Difficulty motivating	Too neat and orderly
Withdrawn/isolating self	Repeating certain behaviors over and over
Cry easily/often	Easily upset or angered
Difficulty making a decision	Feeling different from most people
Difficulty finishing tasks	Shy around others
Thoughts to hurt self	Increasingly forgetful
Attempts to harm yourself	Strong fears
Thoughts to hurt others	Difficulty with work or school
Feeling ill/sick	Stomach aches/vomiting
Threats to hurt others	Use of painkillers & analgesics
Addiction/Compulsion Behavior (pornography, video games, internet, etc)	

MEDICAL HISTORY

Are you currently being treated for any medical problems? Yes No

Are you currently taking any medications? Yes No

List medications:

Dosage	Type	For (i.e. depression)	Prescribed by

Are you currently taking over the counter medications, herbs or supplements? Yes No

Are you presently in good health? Yes No

Do you engage in physical activity? Yes No

If yes, what activity? ___________________________ How often?____________

Do you smoke cigarettes (cigars, chew)? Yes No #______per day

How much alcohol do you drink? #_________per day _________# per week

Do you drink caffeinated beverages? Yes No If yes, how many per day?_____

Do you use illicit drugs? Yes No

If yes, how often and what drugs do you use?____________________________________

Have you ever tried to cut down or stop using alcohol or drugs? Yes No

Has anyone ever asked you to cut down on your drinking? Yes No

Have you ever been hospitalized for any emotional/ mental health condition? Yes No

Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc) Yes No

Do you have a history of domestic violence? Yes No

Do you have a history of verbal, emotional or physical abuse? Yes No

Do you have a history of sexual abuse or sexual assault? Yes No
If you answered 'Yes' to any of the questions in this box, please provide the general details below (including date/duration of events)

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SUPPORT SYSTEMS

Do you have one or two friends that you consider close and feel you can depend on?	Yes No	
Do have a religion or spiritual practice that you experience as supportive?	Yes No	
Do you belong to any social groups or participate in hobbies with people that you enjoy?	Yes No	
Is there a family member that you trust and can go to in times of emotional need?	Yes No	
Are there other people or aspects of your life that you consider supportive?	Yes No	

FAMILY HISTORY

Have you or anyone in your family, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

Has anyone experienced:	**Family Member(s)**
Anxiety	
Depression	
Bipolar disorder	

Learning disorders (ADHD, dyslexia, etc).	
Illicit drug use	
Alcohol abuse	
Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

Marriage or Partnership History (fill in blank where applicable):
Length of relationship with Partner:_______________ Length of Engagement:___________________
Number of Previous Relationships that Lasted More Than 6 Months:____________________________
Date of Marriage:______________________ Number of Breakups/Separations:___________________
Length of Separations/Breakups____
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If this is not your first marriage, please list dates of previous marriages below & primary reasons for divorce:____
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Intimate Relationship Issue Checklist

Seriousness of Issue

Issue	**Not at all**		**Somewhat Serious**		**Extremely serious**
Communication	1	2	3	4	5
Affection	1	2	3	4	5
Physical Attraction	1	2	3	4	5
Sex	1	2	3	4	5
Religion/Spirituality	1	2	3	4	5
Money/Finances	1	2	3	4	5
In-laws (Partner's Family)	1	2	3	4	5
Friends	1	2	3	4	5
Alcohol/Drug Use	1	2	3	4	5
Children/Parenting	1	2	3	4	5
Roles	1	2	3	4	5
Romance	1	2	3	4	5
Recreation/Companionship	1	2	3	4	5
Career Choice (work schedules)	1	2	3	4	5
Stress	1	2	3	4	5
Health Problems	1	2	3	4	5
Legal Issues	1	2	3	4	5
Domestic Violence	1	2	3	4	5
Emotional/Verbal Abuse	1	2	3	4	5
Commitment/Infidelity/Trust	1	2	3	4	5

List 3 of *your* strengths & describe how each strength impacts the life of your partner:
1.
2.
3.

List 3 of your *partner's* strengths & describe how each strength impacts your life:
1.
2.
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Do you find it difficult to assert your feeling or be open & honest with your partner? Yes No

If Yes, please attempt to explain:____

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Do you have children? If yes, please complete box below:

Name	Date of Birth	Age	Where does child reside?

Do any of your children have special needs? ____

Does anyone else currently live in the home? If yes, what is their relationship to you?_______

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Please note any other issues that you think or feel would be good for your psychologist to know:

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~ Thank you ~

COUPLES THERAPY INTAKE QUESTIONNAIRE

(EACH PARTNER NEEDS TO COMPLETE THIS FORM SEPARATELY)

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