COUPLES ASSESSMENT

Please answer the following questions; information will be used to help develop specific goals.

Your Name: ____ Date: _____________

Preferred Primary Language (circle) English Spanish Other: ____________________

Personal Contact: Is it okay to contact you:

At home: By phone? ___yes ___no Leave message? ___ yes ___ no By mail? ___yes ___no

At work: By phone? ___yes ___no Leave message? ___yes ___no By mail? ___yes ___no

Emergency Contact: who to call in case of emergency :

____

Name relationship phone

PERSONAL HISTORY

Your Family of Origin:

	Name	current age	current whereabouts
Father	________________	________	_________________
Mother	________________	________	__________________
Siblings	________________	________	__________________
	________________	________	__________________
	________________	_________	__________________

Your Employment History:

	f/t or p/t	type of work	company name	dates
current	_______	_____________	_______________	______________
	_______	_____________	_______________	______________
Past	_______	_____________	_______________	______________
	_______	_____________	_______________	______________

Previous Marital History:

Former spouse name dates & status children of marriage(names, ages, whereabouts)

_____________________ ______________ ____

_____________________ ______________ ____

Your leisure-time Activities / Hobbies what do you do for fun?

Medical: Do you have any serious medical problems, physical limitations or disabilities? If yes, explain

Mental Illness: Do you (or your parents / siblings) have any history of mental illness? If yes explain

Personal Trauma: Any history of personal trauma? If yes, what and when?

Substance Abuse: Do you (parents or siblings) have any history of abuse of alcohol, drugs or other additions? If yes, explain

Financial Stress: Do you have financial difficulties? If yes, explain

Your Relationship:

1. Date relationship began? _______________________________

2. How did you meet?

3. Why were you attracted to your partner?

4. Do you have any children?

5. Past problems? Have you had problems in the relationship before? If yes when and what did you do about them?

6. Current Problems: What is your main concern about your relationship?

7. Changes Desired: What do you want to see changed as a result of counseling (areas to target)?

8. Problem Areas – please check any that you believe apply to difficulties in the relationship:

___ Conflicting values, core beliefs & life goals

___ Partner's/mine personal psychological problems

___ Partner's/mine use/addiction problems

___ Parenting disagreements

___ Intimacy/sexual

___ Irresolvable conflicts

___ Lack of leisure time activities/togetherness

___ Excessive anger/hostility

___ Verbal abuse

___ Physical abuse

___ Relatives

___ Family background/hx

___ Infidelity

___ Unrealistic expectations

___ Inability to adapt to change

___ Financial/use of resources

___ Life crisis (outside relationship)

9. Prioritize: Of those listed , please prioritize the top three:

1. ________________________________

2.________________________________

3.________________________________

10. Other Actions: Before seeking counseling, what else have you tried to make things better in the relationship?

11. Partner's Strengths: What's the best thing about your partner?

12. Relationship Strengths: What are the strengths in your relationship?

13. Healthy Relationship Description: What things do you think are necessary to have in order to maintain a happy and healthy relationship?