Monica Rodriguez
COUNSELING LLC

COUPLES QUESTIONARE

Name:_____ Age:_____ DOB:_____

Home Ph:_____ Cell Ph:_____

Email: _____

Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact: _____ Phone:_____

Relationship Status:

☐ Never Married ☐ Married ☐ Widowed ☐ Significant relationship

☐ Separated ☐ Divorced ☐ Remarried Number of Marriages:_____

Reason For Seeking Assistance:

_____

_____

_____

_____

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

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated:

_____

_____

_____

General Relationship History:

How long have you and your spouse/partner been together?_____

If married, how many years?_____ How long did you date prior to marriage?_____

Presenting problems: (M = applies to me; S = applies to spouse)

___ very unhappy
___ irritable
___ temper outbursts
___ withdrawn
___ daydreaming
___ fearful
___ worry
___ overactive
___ slow
___ short attention span
___ distractible
___ lacks initiative
___ undependable
___ social problems
___ crying spells
___ hair pulling

___ impulsive
___ stubborn
___ panic attacks
___ lying
___ mean to others
___ destructive
___ trouble with the law
___ health problems
___ self-mutilating
___ stressed out
___relationship problems
___ shy
___ strange behavior
___ strange thoughts
___ physical abuse
___ sexual abuse

___ parenting problems
___ stealing
___ repetitive/ritualistic behaviors
___ grief
___ employment problems
___ financial stress
___ legal problems
___ violence
___ eating problems
___ sleeping problems
___ sexual problems
___ drug use
___ alcohol use
___ suicidal thoughts
___ homicidal thoughts

Explain:

_____

_____

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

_____

Is there anything else you feel is important for me to know?

_____

_____

_____

_____

_____

Signature of Client Date

_____

Signature of Witness Date