

Have either of you ever had psychological counseling or therapy? Y / N

Partner A

Partner B

Psychiatric Diagnoses

Psychiatric Diagnoses

Current Medications

Current Medications

Names, addresses, and telephone numbers of any other professionals consulted.

(They will only be contacted with your written consent.)

<b>Education/Work/Medical History</b>	<u>Partner A</u>	<u>Partner B</u>
Degrees/Diplomas		
Current Employment		
Past Employment		
<i>Significant medical history</i>		

Please provide any information about each of your extended families that might help me understand your needs (medical, behavioral, psychological, educational, and emotional):

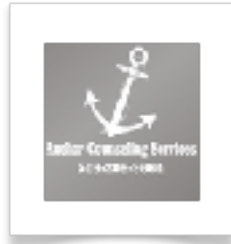
Spiritual Upbringing? Y / N

If Yes, Past denomination

A \_\_\_\_\_ B \_\_\_\_\_

Current Spiritual Practice? Y / N

A \_\_\_\_\_ B \_\_\_\_\_



The following table is designed to assess you and your spouse's ability to relate to others. Circle all that apply.

- Partner A / B Difficulty relating to others?
- Partner A / B Verbally argue a lot with others?
- Partner A / B Difficulty making friends?
- Partner A / B Difficulty maintaining friendships?
- Partner A / B Have at least one good friend?
- Partner A / B Are you invited to friend's houses?
- Partner A / B Like to host others at your house?
- Partner A / B Have a small group of good friends?
- Partner A / B Prefer to be alone?

Do you like your spouse's friends? Partner A Y / N Partner B Y / N  
Add any comments about your social circumstances that are relevant:

What time do you go to bed? A            B            What time do you get up? A            B

Is your sleep consistent? Partner A Y / N Partner B Y / N

Are you concerned that you don't get enough sleep and/or have poor sleep quality?

Alcohol use

Partner A Y / N Please specify: Occasional Weekly Daily

Partner B Y / N Please specify: Occasional Weekly Daily

Drug use

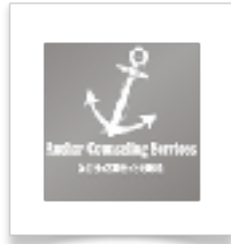
Partner A Y / N Please specify: Occasional Weekly Daily

Partner B Y / N Please specify: Occasional Weekly Daily

Is substance use/abuse a concern for either of you? Y / N

Are you and your spouse currently intimate with each other? Y / N Are you satisfied with your sex life? Partner A: Y / N Partner B: Y / N If no, what would you like to be different?

Do either of you use pornography? Y / N Is this a problem for you or your partner? Y / N



Please describe any major family stressors that may have impacted you in the past or that may impact you now:

Are there any particularly traumatic or troubling events which have happened in your life which I should know about in order to understand you better? (please give details, include incidents you feel were traumatic even though they might not have been for someone else)

Have you ever witnessed violence inside or outside of the home?

Partner A Y / N Partner B Y / N      If yes please specify

What problems or questions have caused you to seek help at this time?

Do you and your Partner agree about the difficulties? Y / N

Does each person want to obtain help? Y / N

Is there any additional information or anything that you feel is pertinent to know that has not been covered in this questionnaire?

Who referred you to Anchor Counseling Services Spokane?

r/5-13-19