

## Pre-Treatment Couples Assessment Form

Please print, complete and bring this form to your first counseling session. The information that you provide will save time and will spotlight the most critical problems within your relationship. Each partner should complete their own form. Please keep your answers limited to one or two sentences where possible. The answers that you provide will be discussed during the treatment sessions.

### General Data

Your name \_\_\_\_\_ Date: \_\_\_\_\_

Partner's name: \_\_\_\_\_

Years married or living together if not married: \_\_\_\_\_ Year married \_\_\_\_\_

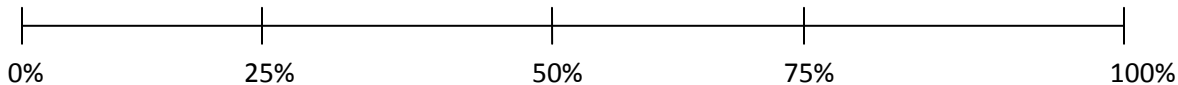
List the names and ages of your biological children and/or children from prior relationships:

List any prior marriages (how many, how long married, year of divorce).

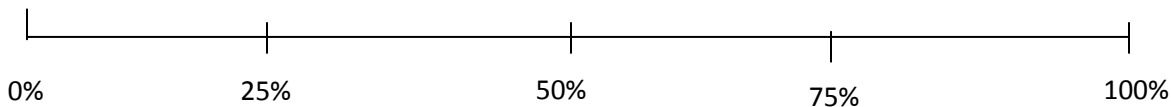
Briefly describe your current occupation (Full time or Part Time, Day, middle, night or weekend shifts? How much overnight travel? Impact upon your relationship?)

### Relationship Data

Please circle any point on the line that best represents how content you feel today about your relationship. The higher values represent a higher sense of contentment.



Please circle any point on the line below that best represents how committed you feel about resolving your relational issues. The higher values represent a higher sense of commitment.



Briefly state the top 3 issues of conflict that keep reoccurring in your relationship or family that you wish to discuss in therapy:

Briefly list any relationship hurts that you have had a hard time getting over (ex. affairs, incidents of abuse, abandonment or neglect.)

Briefly list any significant events that you have experienced within the last 12 months (ex. deaths, job loss, health problems, loss of income.)

Briefly note what you would like your partner to most understand about you.

**Please check items that apply:**

**Moods (ex. Irritability, depression):**

- My moods are a problem to the relationship
- My partner's moods are a problem to the relationship
- Our child's moods are a problem to the relationship

**Alcohol and substance abuse:**

- My use of alcohol and/or other drugs (prescribed or illegal) is a problem to the relationship.
- My partner's use of alcohol and/or other drugs (prescribed or illegal) is a problem to the relationship.
- Our child's use of alcohol and/or other drugs.  
(prescribed or illegal) is a problem to the relationship.

**Anger:**

- My anger adversely affects our relationship
- My partner's anger adversely affects our relationship
- Our child's anger adversely affects our relationship

Circle how intense the anger feels...	
	Mild                      Uncomfortable                      Scary
Me:	----- ----- ----- -----
Partner:	----- ----- ----- -----
Child:	----- ----- ----- -----

**Check off all issues that create ongoing conflict...**

- General chaos    Lack of trust    Finances    Lack of quality time    Parenting
- History of multiple crisis    Loss of love    Lack of sex    Poor communications
- Disengaged partner    Controlling partner    Critical partner    Job demands/stress
- Angry fighting    Spiritual-religious differences    Lack of common interests    In-laws
- Lack of commitment    Extra-marital relationships    Problematic extended family relations
- Drug and/or alcohol abuse    Feeling cut-off & alone    Chronic health & medical issues

Have you ever experienced any traumatizing or life-threatening experience (physical or sexual assault, accidents, combat?) Briefly describe what happened.

Have you had difficult relationships or conflict in your family of origin that could impact your relations with your partner?  Yes  No Briefly state what they were:

Are you currently being treated for or have a history of mental health challenges?

Yes    No      Diagnosis: (depression, anxiety, etc.):

Have you/your partner received medication or psychotherapeutic treatment ?    Yes    No

Have you ever experienced suicide ideation or attempts?    Yes    No

Have you ever experienced hostility, rage or homicidal behavior?    Yes    No

Have you ever had any PFAs enforced against you?    Yes    No

In order to consider couples counseling to be successful, what changes would you need to experience in your relationship?

How motivated do you feel to resolve these problems including changing some of your own relational bad habits in exchange for less stress and a more harmonious relationship?

\_\_\_ I have little to no motivation to work on the relationship.

\_\_\_ I see some value with therapy so long as my partner makes the necessary changes.

\_\_\_ I don't like coming to therapy but I will give it a try if it means less stress at home.

\_\_\_ I am at least open the idea of participating and making some personal changes.

\_\_\_ I am willing to make changes so long as my partner is as well

\_\_\_ I am responsible for my share of the relationship problems and am ready to address them.

Diagnosis:

Name of therapist:

Date intake administered: