(each person please fill out individually without the influence of your partner)

Assessment Questionnaire — Couple

Cottonwood Creek Counseling
Individual, Couple, & Family Therapy

Client Name:_____ **Date of Birth: _____ Gender: _____ Pronouns:_____**

***Current Symptoms Checklist:**

- ☐ Depressed mood
- ☐ Unable to enjoy activities
- ☐ Changes in sleep:
- ☐ Loss of interest
- ☐ Difficulty with concentration
- ☐ Change in appetite
- ☐ Excessive guilt or shame
- ☐ Fatigue :
- ☐ Mood swings
- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Increase in risky behavior
- ☐ Changes in sex drive:
- ☐ Forgetfulness
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Crying spells
- ☐ Obsessions/Fixations
- ☐ Excessive worry
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Hallucinations:
- ☐ Suspiciousness or paranoia
- ☐ Avoidance/Isolation
- ☐ Change in desire/motivation
- ☐ _____
- ☐ _____

***Relationship Status:** _____ (Dating, Engaged, Married, Separated, Divorced, Other)

How long have you been in this relationship? _____ Are you living together? _____

If married, how long did you date before engaged? _____ How long were you engaged? _____

Did you live together before marriage? _____ If yes, how long? _____

List previous marriages or significant long-term relationships: Approx. Dates, Status (widowed, no interaction, hostile, friends), Children?

***Presenting Problem** (What are you seeking help for? Describe the challenges your face—onset, intensity, frequency. When did this begin?):

(each person please fill out individually without the influence of your partner) .

***Attempts to Resolve Presenting Problem** (techniques/resources, duration, effectiveness):

***Past History of Therapeutic Treatment** (type, presenting problem, when, duration, effectiveness, why discontinued):

***Relationship history** (when/what has been successful, what initially attracted you to your partner?):

***Major Life Events in the Past Year** (moves, job changes, deaths, births, illnesses, accidents, injuries, graduation, retirement, empty nest, etc.):

***Values, Beliefs, Interests** (What do you have in common with your partner? What do you not share similar values, beliefs, interests on?):

***Communication Style** (How do you each approach differences and problem solving? How do you communicate about anger, sadness, hurt?):

***Trust Injuries** (cheating, lying, name calling, belittling, secrecy, physical altercations, threats, excessive spending, controlling behaviors. Do you have relationships with other people that create conflict with your partner, and if so, why?):

***Risk Factors** (Present or history of any thoughts, feelings, or actions regarding: suicide, self-harm, homicide, eating disorder, domestic violence, infidelity):

***Intimacy and Sexual Relationship** (level of satisfaction with quality and quantity of sexual exchanges. Do you share intimate communications with your partner of a non-sexual nature?):

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***Spirituality** (Do you identify with a specific religion or belief system, actively participate in meetings, comfort level using in therapy?):

***Financial Decisions** (Do you and your partner generally agree or disagree about money issues? How do you differ?):

***Strengths and Support System** (describe friends and family support, your personal strengths, desire and commitment to make changes):

***Challenges** (what will be difficult for you in making desired change? Impatient, stubborn, disabilities, lack of support, etc.):

***Employment** (company, position, number of hours per week, length of time with company/position, satisfaction, difficulties):

***Individuals living in the home** (name, relation, age):

***Other immediate family members not living in the home** (name, relation, age):

***Extended Family Interactions** (individuation, quality and quantity of interactions with, supportive vs. contentious of your relationship with partner):

***Mental Health History** (personal and family history of: depression, anxiety, OCD, bipolar, schizophrenia, psychiatric hospitalization; diagnoses received):

***Current Medications** (name, purpose, dosage, effectiveness, side effects, start date, date of last adjustment, doctor prescribing medication):

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***Medical History** (personal: surgeries, major illnesses, chronic pain, formal diagnoses; family history):

***For Women Only:** Any difficulties with menstruation:_____

Are you currently pregnant or do you think you might be pregnant? (◯) Yes (◯) No

Are you planning to get pregnant in the near future? (◯) Yes (◯) No

Birth control method _____ (if applicable)

How many times have you been pregnant? _____ How many live births? _____

***Alcohol and Substance Use** (alcohol, cigarettes, tobacco, chew, marijuana, recreational substances, others [indicate present or past and frequency]):

***Dependence/Addiction History** (present and past: drug and alcohol, caffeine, sexual, pornography, gaming, social media, spending, gambling):

***History of Abuse** (physical, sexual, rape, trauma: when, how long did it continue, was a report made, current safety measures if necessary):

***Identify at least three areas or behaviors that you personally could change to improve your relationship:**

***Goals you desire to accomplish through therapy**:

***Additional Information:**

Person filling out form: _____ _____ _____

Print Signature Date

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