L. Gordon Psychotherapy
2718 Telegraph Avenue, Suite 210
Berkeley, CA 94704
510-761-5609
MFT #50459

Couples Questionnaire

Please fill this form out completely. If you are not sure how to answer a question, leave it blank and discuss it with your counselor. Write N/A for those that don't apply.

Client Information:

Name: _____ D.O.B: _____

Occupation: _____ Education: _____

*Who were you referred by? _____

Current Relationship Status: (Please check all that apply):

___ living together ___ dating ___ engaged ___ married ___ separated ___ divorced ___ monogamous
____ open ___ polyamorous _____ other: _____

Relationship History:

How long have you known your partner?

_____

How long have you been in a relationship with your partner?

_____

How long have you been experiencing relationship difficulties with your partner?

_____

Have you ever been married in the past? If so, were you divorced or widowed?

_____

Current Home Environment:

Do you have children and/ or stepchildren? If, so how many and what are their living arrangements?

_____

_____

Do you currently have any relatives or friends living in the home with you? If so who?

_____

_____

Goals for Attending Counseling:

I am attending couples counseling because: (Please check all that apply):

_____It is important to my partner
_____Family/ friends encouraged my partner and I
_____I want to improve my relationship with my partner
_____ Other:

_____It is important to me
_____The next step is separation
_____ The next step is divorce

_____

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Desired outcomes for self (Please check all that apply):

_____ Get more of my needs met in my relationship
_____ Communicate effectively with my partner
_____ Express my anger without hurting my partner
_____ Feel better about myself
_____ Decrease feelings of jealousy
_____ Be more patient with my partner
_____ Be more supportive of my partner
_____ Feel more secure in my relationship
_____ Be less critical of my partner
_____ Other:

_____

Desired outcomes for couple (Please check all that apply):

_____ Participate in new activities as a couple
_____ Take an interest in each other's hobbies
_____ Verbalize thoughts & feelings effectively
_____ Learn how to disagree in a calm way
_____ Improve sexual relationship
_____ Improve parenting of children
_____ Other:
_____ Laugh and enjoy each other as a couple
_____ Show affection with each other
_____ Spend more time together
_____ Be honest with each other about our feelings
_____ Increase the level of trust in our relationship
_____ Work together as a team

_____

Areas of Concern: (Please check all that apply and the counselor will seek additional information if needed):

_____Abuse/ Domestic Violence (__currently or___ in the past)
_____Children
_____Communication Styles and/ or patterns (Verbal/Non Verbal)
_____Critical Partner
_____Elder Care Concerns/ Stressors
_____Expression of Love/Affection
_____Extended Family/In-Law Relationships
_____Extramarital Relations/Affair/Infidelity
_____Financial Stressors that Lead to Relationship Conflict
_____Household Responsibility/Roles
_____Infertility
_____Pregnancy Loss
_____Intimacy/Sexual Concerns
_____Medical Diagnosis of Partner or Self
_____Medical Diagnosis of Child
_____Mental Health Concerns
_____Physical Care of Partner
_____Previous Marriage/Step-Child(ren) Relationship Concerns
_____Religion/Spirituality/Culture
_____Recent Legal Problems
_____Recent Loss of Loved one or Friend
_____Substance Use
_____Suicidal Thoughts
_____Homicidal Thoughts
_____Time Spent Together
_____Difference in Work Schedule
_____Lack of Trust
_____Lack of Support From Partner for Career, Interests, Hobbies
_____Work/ Career Concerns
_____ Other (Please List):

_____

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How has your life been impacted by your relational problems? (Please check all that apply):

_____ Sleeping problems
_____ Eating habits have changed
_____ Effecting my job
_____ Feeling irritable
_____ Feeling fearful
_____ Feeling angry
_____ Difficulty parenting
_____ Increased fighting with friends or family
_____ Financial trouble
_____ Less time with family and friends
_____ Feeling sad
_____ Feeling lonely
_____ low self-esteem
_____ Other:

_____

Have there been any major changes in your life in the past 6 months? (Please check all that apply):

_____ Death of friend or family
_____ Move
_____ Birth of child
_____ Pregnancy loss
_____ Friends or family moved
_____ Diagnosis of medical condition
_____ Other:
_____ Loss of job
_____ Change in job
_____ Pregnancy
_____ Adoption
_____ Went back to school
_____ Friend or family moved into home

_____

Have you ever attended couples counseling in the past? If so, when and for what concerns?

_____

_____

Have you ever sought counseling for yourself? If so, when and for what concerns?

_____

_____

Have you ever been diagnosed with a mental or emotional disorder? If so, when and what?

_____

_____

Are you currently on any medications? If so, please list the medications and the conditions they treat:

_____

Any other information that will be helpful for us to know about you and/ or your relationship?

_____

_____

The information contained herein is complete and truthful to the best of my/our ability.

Client Signature: _____ ***Date:*** _____

Client Signature: _____ ***Date:*** _____

Therapist Signature: _____ ***Date:*** _____