
# Questionnaire

* *indicates a required field*

Prior to your first appointment, please answer all questions below. Do not spend too much time on any question.

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* Name of partner:

* Relationship status (check all that apply):

Married

Separated

Divorced

Dating

Cohabitating/living together

Living apart

* Length of time in current relationship:

* As you think about the primary reason that brings you here, how frequently does it occur?

No occurrence

Occurs rarely

Occurs sometimes

Occurs frequently

Occurs nearly always

* As you think about the primary reason that brings you here, how would you rate your overall concern about it?

No concern

Little concern

Moderate concern

Serious concern

Very serious concern

* What do you hope to accomplish through counseling?

* What have you already done to deal with the difficulties?

* What are your biggest strengths as a couple?

* Please rate your current level of relationship happiness by selecting the number that corresponds with your current feelings about the relationship:

1 = Extremely unhappy

2

3

4

5

6

7

8

9

10 = Extremely happy

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

Yes

No

* Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does:

* If you have received prior couples counseling, when did this occur? (If you have not received prior couples counseling, please type N/A.)

* If you have received prior couples counseling, where did this occur? (If you have not received prior couples counseling, please type N/A.)

* If you have received prior couples counseling, who counseled you? (If you have not received prior couples counseling, please type N/A.)

* If you have received prior couples counseling, what was the length of treatment? (If you have not received prior couples counseling, please type N/A.)

* If you have received prior couples counseling, what were the problems that were treated? (If you have not received prior couples counseling, please type N/A.)

* Have either you or your partner been in individual counseling before?

Yes

No

* Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

Yes

No

* If you have received prior couples counseling, what was the outcome? (If you have not received prior couples counseling, please type N/A.)

Much worse

Somewhat worse

Stayed the same

Somewhat successful

Very successful

N/A

* If married, has either of you threatened to separate or divorce as a result of the current relationship problems? If not married, please answer N/A.

Yes

No

N/A

* Have either you or your partner struck, physically restrained, used violence against, or injured the other person?

Yes

No

* Do you perceive that either you or your partner has withdrawn from the relationship?

Yes

No

* If married, have either you or your partner consulted with a lawyer about divorce? If not married, please answer N/A.

Yes

No

N/A

* How frequently have you had sexual relations during the last month?

* How satisfied are you with the frequency of your sexual relations?

1 = Extremely unsatisfied

2

3

4

5

6

7

8

9

10 = Extremely satisfied

* How enjoyable is your sexual relationship?

1 = Extremely unpleasant

2

3

4

5

6

7

8

9

10 = Extremely pleasant

* What is your current level of stress (overall)?

1 = No stress

2

3

4

5

6

7

8

9

10 = High stress

* What is your current level of stress (in the relationship)?

1 = no stress

2

3

4

5

6

7

8

9

10 = high stress

* List your top three concerns that you have in your relationship with your partner (1 being the most problematic):

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Thank you for completing this. Please note that you will be asked to talk about your answers in appointments, but your partner will not be shown this form.