

## Couple Counseling Assessment

### Personal Information

First name:	Last name:
Age:	Date of birth:
Ethnicity:	Religion:
Marital status:	Number of children and their ages:
Sex/gender:	

Name of partner:

Telephone:

### Marriage Details

When and where did you meet?

What first attracted you to the other person?

When did you decide to get married?

### Marital Issues

Have there been any significant issues or obstacles in the marriage? What were they?

How satisfied are you with the marriage? (Where 0 is extremely unsatisfied and 10 is extremely satisfied)

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

If you could change one thing about yourself, what would it be?

If you could change one thing about the other person, what would it be?

What are you hoping for from counseling? What are your treatment objectives?

For example:

- Problem solving
- Improve communication
- Increase quality time together
- Increase intimacy
- Improve respect and understanding
- Be more intimate
- Improve parenting skills
- Anything else?

### Any Stressful Life Events

Please capture any stressful life events that may be impacting the relationship in the box below

Type of problem/worries	Yes/No	If yes, please describe:
Financial	<input type="checkbox"/> / <input type="checkbox"/>	
Health/illness	<input type="checkbox"/> / <input type="checkbox"/>	
Family conflict	<input type="checkbox"/> / <input type="checkbox"/>	

Type of problem/worries	Yes/No	If yes, please describe:
Bereavement/grief	<input type="checkbox"/> / <input type="checkbox"/>	
Accommodation	<input type="checkbox"/> / <input type="checkbox"/>	
Educational	<input type="checkbox"/> / <input type="checkbox"/>	
Friends	<input type="checkbox"/> / <input type="checkbox"/>	

### Other Areas to Focus on

Tick all the following that apply:

Area	Yes/No	Details
Difficulty in expressing thoughts	<input type="checkbox"/> / <input type="checkbox"/>	
Not feeling heard	<input type="checkbox"/> / <input type="checkbox"/>	
Disrespect	<input type="checkbox"/> / <input type="checkbox"/>	
Conflict	<input type="checkbox"/> / <input type="checkbox"/>	
Verbal or physical abuse	<input type="checkbox"/> / <input type="checkbox"/>	
Unsure of our problems	<input type="checkbox"/> / <input type="checkbox"/>	

Area	Yes/No	Details
Lack of sexual intimacy	<input type="checkbox"/> / <input type="checkbox"/>	
Lack of sexual satisfaction	<input type="checkbox"/> / <input type="checkbox"/>	
Inability to compromise	<input type="checkbox"/> / <input type="checkbox"/>	
Decision making is not shared equally	<input type="checkbox"/> / <input type="checkbox"/>	
Insufficient quality time together	<input type="checkbox"/> / <input type="checkbox"/>	
Not feeling valued	<input type="checkbox"/> / <input type="checkbox"/>	
Committed adultery	<input type="checkbox"/> / <input type="checkbox"/>	
Lack of boundaries with friends or families	<input type="checkbox"/> / <input type="checkbox"/>	
Unfair distribution of household chores	<input type="checkbox"/> / <input type="checkbox"/>	
Financial concerns	<input type="checkbox"/> / <input type="checkbox"/>	
Unhappiness with job	<input type="checkbox"/> / <input type="checkbox"/>	
Work schedule interferes with relationship	<input type="checkbox"/> / <input type="checkbox"/>	
Poor mental or physical health	<input type="checkbox"/> / <input type="checkbox"/>	