Couples Therapy Assessment Form

Names:

Partner A: ____

Partner B: ____

Address: ____

____

Occupations:

Partner A: ____

Partner B: ____

Number of Children – Biological, Step-Children, Names And Ages (stipulate children together and children from Previous relationships):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

History of Mental Illness (depression, anxiety, bi-polar disorder, post traumatic stress disorder, ADHD, other)

Partner A:____

____

Partner B: ____

____

Medications for Mental Illness and/or Physical Ailments:

Partner A: ____

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____

Partner B: ____

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____

Health Habits:

Smoker: (Y or N) Partner A:__________ B:__________

Regular Exercise (type) Partner A:____________________________

____

Partner B: ____

____

Alcohol or Marijuana Use (how much and how often):

Partner A: ____

____

Partner B:____

____

Other Drug Use (street drugs):

Partner A: ____

Partner B: ____

History of Abuse (specify: physical, emotional, or sexual):

Partner A: ____

____

Partner B: ____

____

Parent's Marital Status while growing up:

Partner A: ____

Partner B____

Relationships with immediate family members; parents, siblings, and adult children (specify: close, speaking terms, no communication):

Partner A: ____

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____

Partner B: ____

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Current Relationship problems which couple is seeing help:

Partner A – Perspective ____

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____

Partner B – Prespective: ____

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