Claret Center
Couples Information Questionnaire
Confidential

Identification Information

Your name: ______________________________ cell phone: ____________________ age ____________
address: ______________________________ private email: ____________________ birthdate ____________
city, state, zip ______________________________ occupation: ____________________ mm/day/yr
place of Employment: ____________________

I give permission to communicate through my email listed above: ☐ Yes ☐ No
I give permission to communicate by text: ☐ Yes ☐ No

Highest level completed (circle): Grade School High School GED College: Associates Bachelors Masters Doctoral
college degree & major ____
graduate degree(s) & field ____
other ____

Religious background
Religious affiliation: ______________________________
How important to you are spiritual matters? ___not ___little ___moderate ___much

Relationship Status: (circle)

Engaged Married Partnered Living Together Separated

Length of time in relationship_____________ If married, your ages when married: __________________________

Previous marriages:

Date of Marriage	Broken by death?	Broken by Divorce?	Date When Broken
	Y N	Y N	
	Y N	Y N	

If have children, information about them

Name	Age	Living? (circle one)	Living at home? (circle one)
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N

Others living in your home besides children (names, ages, their relation to you)

Family of Origin

Were you reared by your blood parents? ☐ Yes ☐ No
Were your parents divorced? ☐ Yes ☐ No If yes, approximate year________________

Parents or parental figures

Name	age	living? (circle one)	marital status (circle one)	estimated level of happiness 1 (unhappy) thru 10 (very happy)
		Y N	S M W D	
		Y N	S M W D	
		Y N	S M W D	
		Y N	S M W D	

Brothers and Sisters in Birth Order

Name	age	living? (circle one)	marital status (circle one)
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D

Relationship Concerns

Please check any of the reasons listed below that resulted in this request for counseling:

- ☐ pre-marital counseling
- ☐ relationship enhancement
- ☐ improve sexual relations
- ☐ communication difficulties
- ☐ depression
- ☐ marital problems
- ☐ verbal abuse
- ☐ physical abuse
- ☐ anxiety
- ☐ alcohol/drug abuse
- ☐ other addiction:
- ☐ divorce counseling

Please indicate your current level of relationship happiness by circling a number:

Extremely unhappy		Unhappy	Fairly unhappy	Happy	Fairly happy		Extremely happy		Perfect
1	2	3	4	5	6	7	8	9	10

What is the major challenge?

____
____
____
____

How long have you had this challenge?____

As you think about the primary reason that brings your here, what is your current overall level of concern?

_____no Concern _____little concern _____moderate concern _____serious concern

Were there other times you have had similar problems? If so when?

____
____
____

What recurring patterns do you see in the ways things go wrong between you and your partner?

What part do you have in maintaining the problem?

Why are you seeking help now?

What have you already done to deal with the difficulties?

What are your biggest strengths as a couple?

What would you like to see happen as a result of therapy?

Please make at least one suggestion as to something you could personally do to improve the relationship that is independent from your partner's behaviors:

How enjoyable is your sexual relationship?

- ☐ great
- ☐ more pleasant than unpleasant
- ☐ not unpleasant
- ☐ not pleasant
- ☐ More unpleasant than pleasant
- ☐ terrible

How satisfied are you with the frequency of your sexual relationship?

- ☐ too often to suit me
- ☐ a bit too often to suit me
- ☐ about right
- ☐ a bit seldom to suit me
- ☐ far too seldom to suit me

Do you love your partner? ☐ Yes ☐ No

Please list the personal characteristics and values in your partner you find attractive, admirable, and enjoyable:

Have you received prior couples counseling for any of the above problems? ☐ Yes ☐ No
When: ____________________________
Problem treated: ____
Outcome (please circle):
very successful somewhat successful no change somewhat worse much worse

Have either of you threatened to separate or end the relationship as a result of your current problem(s). If so, when?
____

Have you ever been separated as a couple? ☐ Yes ☐ No
If so, when? _________________Who left? ________________How long did the separation last?_________________

Have either of you or your partner struck, physically restrained, or injured the other person? ☐ Yes ☐ No
If so, when? ____________________________Who initiated ___________________________________

Health Information

On average how many hours of sleep do you get a night? _________ hours.
On average, how many days per week do you exercise and for how long? ______ days a week for ______minutes a day.
On average, how much alcohol do you consume during the week?_______________
Do you smoke?______ If yes, how much?_____________

Do you use street drugs and/or pharmaceuticals for recreational purposes? ☐ Yes ☐ No
If yes, please describe the frequency and what substance is used:

____
____
____

Have you received help for drug or alcohol dependency or other addictions? ☐ Yes ☐ No
When____________________________________ Where did treatment occur?_____________________

Have you been hospitalized for mental/emotional/psychiatric reasons? ☐ Yes ☐ No. If yes, when, where, and for what reasons:

____
____
____

If you are currently taking any medications, related to depression, anxiety or any emotional or psychiatric difficulties, please name them and their purpose.

____
____

Prescribing Physician_________________ Psychiatrist_____________________ Other _________________________

Have you ever had thoughts of harming yourself or someone else? ☐ Yes ☐ No. If yes, how recently? ____________

Please provide any other information you think will be necessary or helpful

____
____
____
____

Signature____ Date ____________________________

Insurance Information

We accept most Blue Cross/Blue Shield PPO plans. If you choose for us to submit claim to your insurance, do we have your permission to file claims, treatment plans and have contact with your insurance? ☐ Yes ☐ No.
If yes, please provide, at your first session, a copy of your current insurance card and driver's license
and **sign here →**______________________