

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: _____

Partner B: _____

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: _____

Partner B: _____

Current Relationship problems which couple is seeing help:

Partner A – Perspective _____

Partner B – Prespective: _____

After completing form, please click the SUBMIT Button. This will open a new email using your default email application. If you do not have one installed on your device, just save the form and email it to clbarrow66(AT)gmail.com. *Please be sure to input the email correctly as you are emailing Private & Confidential information.*