

**(Beloveds/Amadx)**  
**Relationship Counseling Partner Questionnaire**

**PERSONAL INFO**

Name/Preferred Name:

Date of Birth:

Age:

Pronouns:

Relationship Status:

Partner/s/Spouse Name/s:

Children (Names and ages):

Others living in your home? Pets?

Livelihood:

**CONTACT INFORMATION**

Email address:

Phone number(s):

**EMERGENCY CONTACT**

Name:

Relationship to you:

Address:

Phone:

**PAST YEAR CHECKLIST**

Please respond to what applies to you. Please rate the level of distress these issues have caused you in the past year:

- 0 (None)
- 1 (Minor)
- 2 (Moderate)
- 3 (Considerable)
- 4 (Extreme)

- \_\_\_ Sleeping Too Much/Too Little
- \_\_\_ Eating Too Much/Too Little
- \_\_\_ Mood Swings
- \_\_\_ Angry Outbursts
- \_\_\_ Depression
- \_\_\_ Repetitive Behaviors
- \_\_\_ Anxiety/Fear
- \_\_\_ Lack of Energy
- \_\_\_ Hear/See things others can't
- \_\_\_ Suicidal Thoughts/Actions
- \_\_\_ Physical/Emotional/Sex. abuse
- \_\_\_ Drug/Alcohol (self or other)
- \_\_\_ Loneliness
- \_\_\_ Experienced Discrimination/Oppression
- \_\_\_ Spiritual Conflicts
- \_\_\_ Death/Major Loss
- \_\_\_ Past trauma
- \_\_\_ Health Problems
- \_\_\_ Sexual Problems
- \_\_\_ Relationship Problems
- \_\_\_ Education/Work Concerns
- \_\_\_ Financial Concerns
- \_\_\_ Legal Difficulties
- \_\_\_ Major Life Transition
- \_\_\_ Gender Identity Conflict
- \_\_\_ Sexual Identity Conflict
- \_\_\_ Cultural Concerns

### **EXPECTATIONS FOR RELATIONSHIP COUNSELING**

What brings you to seek relationship counseling now and what do you hope to gain?

Past experiences in relationship therapy/couples therapy or individual counseling/psychotherapy? Positive or Negative? Concerns?

### **MEDICAL AND MENTAL HEALTH TREATMENT INFORMATION**

Please describe your physical and mental health including significant hospitalizations, illnesses, and/or medications.

Are you currently receiving other mental health services or medical treatments?

### **SAFETY ASSESSMENT**

Have you ever given serious consideration to, or attempted to end your own life?

Have you ever given serious consideration to, or attempted to harm another person?

### **SUBSTANCE USE**

Do you currently use tobacco, alcohol, or other drugs? Please tell me more.

Substance:

How much and how often?

Past substance abuse treatment?

### **LEGAL HISTORY**

Are you involved in the legal system or have you had significant legal issues in the past?

## **FAMILY INFORMATION**

Please give me a brief family history that is relevant to relationship counseling. Describe family of origin and your current family dynamics:

## **RELATIONSHIPS WITH OTHERS**

Please describe the important people in your life and the quality of these relationships:

Have you now or ever experienced violence, abuse, or threatening behavior in a relationship?

Do you have any concerns related to gender identity? Sexual identity?  
Another emergent identity (ie: kinky, poly, etc.?)

## **TRAUMA HISTORY**

Please tell me about any past traumatic experiences you have had that are relevant to relationship therapy (including but not limited to childhood abuse, military combat, assault, natural disasters, life threatening illness).

## **STRENGTHS AND RESOURCES**

What helps you personally to make it through difficult times in your relationship/s?

What provides joy and nourishment outside of your relationship/s?

Do you have religious practices or spiritual beliefs that are important to you?

Is there anything else that you think I should know?