Strong Loving Connections
Couples Counseling Questionnaire

Horsham, PA 19044

Please help me to get to know you and your relationship by completing without your partner's help. Each partner will complete their own questionnaire. (If more space is needed to answer, use back.)

	Name	Date of Birth	Occupation
You	_____		
Your partner	_____		

(Circle One) Engaged / Married / Separated / Divorced / Live Together / Other_____

How long have you been in this relationship? _____

If married, how long have you been married? _____

If you lived together before marriage, how long? _____

Children: Name Sex Date of Birth Is child yours, partner's or both?

_____

_____

_____

_____

List major relationships you had before your partner, current status of relationship and children:

_____

_____

What concerns bring you to couple's counseling?

_____

_____

_____

_____

www.ellenschrier.com
215-593-9167

Strong Loving Connections
Couples Counseling Questionnaire
Horsham, PA 19044

What goals do you have for your relationship? _____

_____

_____

Have you had therapy or couple's counseling in the past and, if so, what and when? _____

_____

If so, what was helpful? _____

What was not helpful? _____

How do you handle conflict between the two of you? _____

_____

And your partner? _____

_____

What do you do when you are angry? _____

_____

And your partner? _____

_____

What traits do you appreciate in your partner? _____

_____

What traits do you think your partner appreciates in you? _____

_____

Describe 2 behaviors you <u>personally</u> could change to make relationship better: _____

_____

Describe 2 of your partner's behaviors which are challenging to you: _____

_____

On a scale of 1 to 10, how open are you in expressing your innermost wants, thought, desires and feelings to your partner? (1 being totally closed and 10 being totally open)

_____

When you feel like you want support or encouragement from your partner, do you get it? How?

_____

_____

When you partner wants support or encouragement from you, do you feel that you give it? How?

_____

_____

Describe your sexual relationship. _____

_____

How has your sexual relationship changed since you were first together? _____

_____

What is one thing that you wish were different about your sexual relationship? _____

_____

Do you have joint commitments to goals, projects, work or social causes? _____

_____

Have there been any incidents of physical violence or threat of violence?_ _____

If yes, describe: _____

Do you or your partner have difficulties with alcohol or substance abuse? _____

If yes, describe:_____

_____

FAMILY OF ORIGIN

What strengths do you remember in your family of origin? _____

_____

What weaknesses do you remember in your family of origin? _____

_____

_____

Was there any physical or sexual abuse in your family? _____If yes, what kind of abuse and with who? _____

List any important events or "family secrets" in your family of origin: _____

_____

_____

_____