



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?



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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 personally could change to make relationship better: _____

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



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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 your 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: _____



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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: _____
