Shirin Shahrokhi
(818) 912-9972
5535 Balboa Blvd., Suite 100
Encino, CA 91316

Couples Questionnaire

Please fill this form out completely. If you are not sure how to answer a question, leave it blank and discuss it with your therapist. Write N/A for those that don't apply.

Client Information:
Name: _____ D.O.B. _____

Occupation: _____ Education: _____

*Who were you referred by? _____

Current Relationship Status: (Please check all that apply)
_____living together _____dating _____ engaged _____married _____separated
_____divorced _____monogamous _____open _____polyamorous _____other: _____

Relationship History:
How long have you known your partner?
_____
How long have you been in a relationship with your partner?
_____
How long have you been experiencing relationship difficulties with your partner?
_____
Have you ever been married in the past? If so, were you divorced or widowed?
_____

Current Home Environment:
Do you have children and/or stepchildren? If so, how many and what are their living arrangements?
_____
_____
Do you currently have any relatives or friends living in the home with you? If so, who?
_____
_____

Goals for Attending Counseling:
I am attending counseling because: (Please check all that apply)

_____ It is important to my partner
_____ Family / friends encouraged my partner and I
_____ I want to improve my relationship with my partner
_____ Other: _____
_____ It is important to me
_____ The next step is separation
_____The next step is divorce

Desired Outcomes for Self: (*Please check all that apply)*

_____ Get more of my needs met in my relationship
_____ Communicate effectively with my partner
_____ Express my anger without hurting my partner
_____ Feel better about myself
_____ Decrease feelings of jealousy
_____ Be more patient with my partner
_____ Be more supportive of my partner
_____ Feel more secure in my relationship
_____ Be less critical of my partner
_____ Other: _____
_____

Desired Outcomes for Couple: (*Please check all that apply)*

_____ Participate in new activities as a couple
_____ Take an interest in each other's hobbies
_____ Verbalize thoughts & feelings effectively
_____ Learn how to disagree in a calm way
_____ Improve sexual relationship
_____ Improve parenting of children
_____ Laugh and enjoy each other as a couple
_____ Show affection with each other
_____ Spend more time together
_____ Be honest with each other about our feelings
_____Increase the level of trust in our relationship
_____ Work together as a team
_____ Other: _____

Areas of Concern: (*Please check all that apply)*

_____ Abuse / Domestic Violence (_____ currently or _____ in the past)
_____ Children
_____ Communication styles and/or patterns (verbal/non verbal)
_____ Critical Partner
_____ Difference in Work Schedule
_____ Elder Care Concerns / Stressors
_____ Expression of Love / Affection
_____ Extended Family / In-Law Relationships
_____ Extramarital Relations / Affair / Infidelity
_____ Financial Stressors that Lead to Relationship Conflict
_____ Household Responsibility / Roles
_____ Infertility
_____ Lack of Trust
_____ Lack of Support from Partner for Career, Interests, Hobbies
_____ Pregnancy Loss
_____ Intimacy / Sexual Concerns
_____ Medical Diagnosis of Partner or Self
_____ Medical Diagnosis of Child
_____ Mental Health Concerns
_____ Physical Care of Partner
_____ Previous Marriage / Step-Child(ren) Relationship Concerns
_____ Religion / Spirituality / Culture
_____ Recent Legal Problems
_____ Recent Loss of Loved One or Friend
_____ Substance Use
_____ Suicidal Thoughts
_____ Homicidal Thoughts
_____ Time Spent Together
_____ Work / Career Concerns
_____ Other (Please list): _____

How has your life been impacted by your relational problems? (*Please check all that apply)*

_____ Sleeping problem
_____ Eating habits have changed
_____ Affecting my job
_____ Feeling irritable
_____ Feeling fearful
_____ Feeling angry
_____ Difficulty parenting
_____ Increased fighting with friends or family
_____ Financial trouble
_____ Less time with family and friends
_____ Feeling sad
_____ Feeling Lonely
_____Low Self-Esteeem
_____ Other: _____
_____

Have there been any major changes in your life in the past 6 months? (C*heck all that apply)*

_____ Death of a friend or family
_____ Move
_____ Birth of a child
_____ Pregnancy loss
_____ Friend or family moved
_____ Diagnosis of medical condition
_____ Loss of job
_____ Change in job
_____ Pregnancy
_____ Adoption
_____ Went back to school
_____ Friend or family moved into home
_____ Other: _____

Have you ever attended couples counseling in the past? If so, when and for what concerns?

_____
_____

Have you ever sought counseling for yourself? If so, when and for what concerns?

_____
_____

Have you ever been diagnosed with a mental or emotional disorder? If so, when and what? Are you currently on any medications? If so, please list the medications and the conditions they treat:

_____
_____

Is there any other information that will be helpful for us to know about you and / or your relationship?

_____
_____

The information contained herein is complete and truthful to the best of my/our ability.

Client Signature: _____ ***Date:*** _____

Client Signature: _____ ***Date:*** _____

Therapist Signature: _____ ***Date:*** _____