Resilient Relationships
Margot Standeven, LMFT, LPC

COUPLE COUNSELING APPLICATION

Please each complete one application

Name: _____ Pronouns: _____ Age: _____

Address: _____

_____

Contact Information	OK to leave messages?	Preferred contact?
Phone:	□ Yes □ No	□ Yes
Email:	□ Yes □ No	□ Yes

How long have you lived in Oregon? _____

How were you referred to this office? _____

PARTNER & CHILDREN

Name of partner: _____

If living together, how long? _____

Are there children living with you? □ Yes □ No

Name_____ Age_____

Name_____ Age_____

Name_____ Age_____

Other individuals living with you? _____

LIFESTYLE

Current Employment: _____

Length: _____ If not employed, how long? _____

Most Recent Education: _____

Religious or Spiritual Affiliation? _____

Support System: _____

What brought you here today? _____

_____

_____

_____

BACKGROUND INFORMATION

Are you experiencing any of the following?

□ Aggression
□ Wide mood swings
□ Anxiety
□ Fatigue
□ Relationship problems
□ Body image concern
□ Overuse of phone/gaming
□ Loneliness
□ Nightmares
□ Obsessive thoughts
□ Memory difficulty
□ Loss of pleasure
□ Guilt/shame
□ Depression
□ Compulsive behavior
□ Stress
□ Sexual problems
□ Chronic pain
□ Sadness
□ Impulsivity
□ Alcohol or drug use
□ Post-partum depression
□ Low self esteem
□ Unhealthy eating habits
□ Issues with fertility
□ Hopelessness
□ Thoughts of death
□ Parenting problems
□ Sleep problems
□ Irritability
□ Self-harm
□ Panic attacks
□ Thoughts of harming others
□ Other:

Are your experiences affecting any of the following?

□ Mental health
□ Everyday tasks
□ Self esteem
□ Recreation
□ Physical health
□ Finances
□ Sexual activity
□ Housing
□ Relationships
□ Future goals
□ Other:

Have you ever had thoughts, made statements, or attempted to hurt yourself?

Have you ever had thoughts, made statements, or attempted to hurt anyone else?

Have you experienced any of the following?

□ Victim of crime
□ Discrimination
□ Physical abuse
□ Multiple family moves
□ Serious auto accident
□ Parental substance abuse
□ Emotional abuse
□ Violence in home
□ Financial hardship
□ Foster home
□ Adoption
□ Life threatening illness
□ Sexual abuse
□ Loss of loved one
□ Homelessness
□ Neglect
□ Other:

Which of your experiences, if any, is your partner not familiar with? _____

_____

_____

HEALTH HISTORY

Access to Healthcare: _____ Date of Last Visit: _____
Current Health Concerns: _____
Past Health Concerns: _____
Surgeries: _____
Current Treatments: _____

Are you on any psychiatric medication now or in the past? _____
_____
Any family members who have been on psychiatric medication, hospitalized or in some other way been treated for mental health issues? _____
_____

Have you ever participated in therapy or counseling before? □ Yes □ No

Dates	**Provider Name**	**Experience positive or negative?**

USE OF SUBSTANCES

Caffeine Intake: _____
Alcohol Use: _____
Cannabis Use: _____
Tobacco Use: _____
Psilocybin Use: _____
Use of Cocaine, Crack, Ecstasy, Heroin, Inhalants, Methamphetamines, Pain killers, PCP/LCD, Steroids, Tranquilizers, or other: _____
_____

Are there members of your family who have had problems with alcohol or drugs?
_____

Is there anything else that you feel is important for me to know?_____
_____
_____
_____

_____
Client signature Date

COUPLES QUESTIONAIRE

1. What are your goals for our work together? _____

   _____

2. What strengths do you have as a couple? _____

   _____

3. When do you feel closest or most connected to your partner? _____

   _____

4. How often do your arguments result in physical fighting such as hitting, grabbing, kicking, throwing things, blocking other person, insults, threats or verbal intimidation? What happens? _____

   _____

5. How satisfying is the quality and amount of sexual intimacy in your relationship? _____

   _____

6. How are you doing as a couple with decision-making, sharing responsibilities? _____

   _____

7. Any significant breaches of trust with your partner? _____

   _____

8. How did your own family model relationships? _____

   _____

9. Would you describe you & your partner as getting caught up in a negative cycle or repeating pattern?

   _____

10. How much does substance use impact or contribute to the situation? _____

    _____

11. How hopeful are you that your relationship will thrive and grow? _____

    _____

12. How much do you feel that your partner cares about you? _____

    _____

13. What do you feel is most responsible for the problems in your relationship? (yourself, your partner, both of you, some other factor/person) _____

    _____

_____

Client signature Date

Adapted from James D. Thomas, LMFT, Institute for Change, P.C., 3500 S Wadsworth Blvd. #403, Lakewood, CO 80235