BALANCE BEHAVIORIAL HEALTH, PLLC

COUPLE QUESTIONNAIRE

Please answer the following questions as completely as possible

Your Name: _____ Date: _____

Medical/Lifestyle History:

Current Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Medication(s) currently used:

Medication/Dose	Date Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Reproductive History: (Female Only)

Number of Pregnancies: _____

Number of Live Births: _____

Currently Pregnant: ☐ Yes ☐ No ☐ Maybe

Past Hospitalizations (Psychiatric/Chemical Dependency):

Date(s)	Reasons	Hospital
_____	_____	_____
_____	_____	_____

Alcohol and/or Drug Use:

How often do you use alcohol? ☐ None ☐ Monthly ☐ Weekly ☐ Daily

On the days that you drink, how many drinks do you usually have?

☐ Less than 2 ☐ 2-5 ☐ 5 or more

Do you consider it a problem? ☐ No ☐ Yes

Do others consider it a problem? ☐ No ☐ Yes

Do you have problems at work/school because of drinking or drug use? ☐ No ☐ Yes

Have you had problems with alcohol in the past? ☐ No ☐ Yes

Marijuana Use: ☐ None ☐ Occasionally ☐ Daily ☐ Weekly

Do you use other non-prescription substances? ☐ No ☐ Yes - what substance? _____

How often? ☐ Occasionally ☐ Daily ☐ Weekly

If you have answered "yes" to any of the above, please complete the last 2 pages of this questionnaire

Nicotine Use:

Do you smoke or use tobacco now? ☐ No ☐ Yes

How much? _____ How Long? _____

Have you smoked or used tobacco in the past? ☐ No ☐ Yes

How much? _____ How Long? _____

Caffeine:

How much cups of caffeinated coffee/tea do you drink a day? _____

How many caffeinated soft drinks? _____ How much chocolate, cocoa? _____

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Mental Health:

Is there a family history of (check all that apply):

☐ Alcoholism ☐ Substance Abuse ☐ Mental Illness ☐ Suicide

If yes, please describe the relationship to you and the problem:

_____

_____

Have you attempted suicide? ☐ No ☐ Yes

Do you currently have suicidal thoughts? ☐ No ☐ Yes

Do you ever feel angry enough at home/work/school to do something that you might regret?

☐ No ☐ Yes

Childhood History:

As a child did you have any problems with:

☐ Learning Disabilities	☐ No	☐ Yes	_____
☐ Hyperactivity	☐ No	☐ Yes	_____
☐ Bed Wetting	☐ No	☐ Yes	_____
☐ School Fears	☐ No	☐ Yes	_____
☐ Depression	☐ No	☐ Yes	_____
☐ Sexual or Physical Abuse	☐ No	☐ Yes	_____

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?

☐ No ☐ Yes - If yes, please describe:_____

_____

_____

Family History:

Which of the following best describes the family in which you grew up?:

Warm and Accepting				Average			Distant, Hostile and Fighting	
1	2	3	4	5	6	7	8	9

Was the family/home disrupted by serious illness/accident/death/separation/divorce?

☐ No ☐ Yes - If yes, please describe:_____

_____

_____

Legal History:

☐ None ☐ Litigation ☐ Arrest ☐ Victimization, specify_____

Job Satisfaction:

☐ Very Satisfied ☐ Fairly Satisfied ☐ Not At All Satisfied

Have you ever taken work leave for mental health/chemical dependency problems?

☐ No ☐ Yes, how long _____

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Previous Counseling, EAP, or Chemical Dependency Services:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy	☐ No	☐ Yes	Marital/Couples Therapy	☐ No	☐ Yes
Group Psychotherapy	☐ No	☐ Yes	Sex Therapy	☐ No	☐ Yes

If Yes, please list:

Facility/Counselor Name	Dates Seen	Reason Seen	Helpful?
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes

Relationship Issues:

What is the main issue you are seeking help with: _____

_____

_____

_____

How and when did you and your partner meet: _____

_____

_____

_____

What most attracted you to your partner when you met:_____

_____

_____

_____

_____

_____

What do you fight most about now: _____

_____

_____

_____

_____

_____

What do you do for fun together:_____

_____

_____

_____

How did your parents get along:_____

_____

_____

Do you still love each other: ☐ No ☐ Yes

If yes, how does your partner show you love:_____

_____

_____

_____

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Symptom Checklist

Please check all of the following problems/symptoms which pertain to you.

( ) panicky feelings
( ) nervousness
( ) anxiety
( ) fears
( ) phobic avoidance
( ) procrastination
( ) nervous tics
( ) driven to perform certain behaviors
( ) headaches
( ) chest pains
( ) rapid heart beat
( ) dizziness
( ) excessive sweating
( ) appetite problems
( ) weight loss/gain
( ) bowel/stomach trouble
( ) binging
( ) vomiting
( ) purging
( ) muscle tension
( ) pain
( ) hearing problems
( ) menstrual problems
( ) sexual problems

( ) drug/alcohol abuse
( ) depression
( ) unhappiness
( ) seasonal variations in mood
( ) tearfulness
( ) loss of interest
( ) sleep problems
( ) nightmares
( ) fatigue
( ) low self-esteem
( ) memory problems
( ) reduced concentration
( ) withdrawal
( ) no sense of purpose
( ) shyness
( ) loneliness
( ) relationship problems
( ) job problems
( ) educational problems
( ) financial problems
( ) career issues
( ) boredom
( ) temper outbursts
( ) anger problems
( ) loss of control

( ) suspicious of others
( ) hearing unidentified voices or sounds
( ) guilt
( ) jealousy
( ) difficulty making decisions
( ) homicidal thoughts
( ) suicidal thoughts
( ) history of abuse
( ) flashbacks
( ) time loss
( ) feeling out of body
( ) feeling unreal
( ) smelling unidentified odors
( ) sensitivity to noise or lights
( ) racing thoughts

THANK YOU FOR YOUR TIME AND COOPERATION!

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The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many standard drinks containing alcohol do you have on a typical day when drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. During the past year, how often have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. During the past year, how often have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. During the past year, have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	

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The Drug Abuse Screening Test

Directions: The following questions concern information about your involvement with drugs. "Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs. The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). The questions do not include alcoholic beverages. Consider the past year (12 months) and carefully read each statement. Then decide whether your anxer is YES or NO and check the appropriate space. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you use more than one drug at a time?	No	Yes
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	No	Yes

Comments: Scoring Score 1 point for each question answered “Yes,” except for question 3 for which a “No” receives 1 point.

DAST Score: _ _

Interpretation of Score: Score Degree of Problems Related to Drug Abuse Suggested Action

0 None at this time
1-2 Low level Monitor, reassess at a later date
3-5 Moderate level Further investigation
6-8 Substantial level Intensive assessment
9-10 Severe level Intensive assessment