BALANCE BEHAVIORIAL HEALTH, PLLC

COUPLE QUESTIONNAIRE

Please answer the following questions as completely as possible

Patient/Significant Other 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 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

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? __________________________

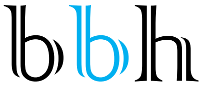
How many caffeinated soft drinks? ___________ How much chocolate, cocoa? ___________

Drug Use:

Marijuana: ☐ None ☐ Occasionally ☐ Daily☐ Weekly

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

How often? ☐ Occasionally ☐ Daily ☐ Weekly



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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:____

____

____

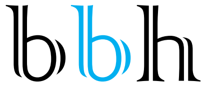
Do you still love each other: ☐ No ☐ Yes

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!