PREVAIL COUNSELING GROUP, PLLC

COUPLE CLIENT QUESTIONNAIRE

"Please complete this questionnaire prior to your first appointment. Your answers will allow the therapist to have a better understanding of your problem(s). Feel free to ask questions if you need assistance."

Today's Date:_________________

Who referred you to Prevail Counseling Group?____

Partner 1

Name: ____

Date of Birth: ___________________________ Current Age: ____

Gender: Male [ ] or Female [ ] Social Security Number: ________________________________

Race: [ ] African/American [ ] Asian [ ] Hispanic [ ] Native/American [ ] Caucasian [ ] Other

Partner 2

Name: ____

Date of Birth: ___________________________ Current Age: ____

Gender: Male [ ] or Female [ ] Social Security Number: ________________________________

Race: [ ] African/American [ ] Asian [ ] Hispanic [ ] Native/American [ ] Caucasian [ ] Other

Address: ____
(Street Address) (City, State, Zip Code)

Home Phone: ___________________________ May we leave a message? [ ] Yes or [ ] No

Work Phone (1)___________________________ May we leave a message? [ ] Yes or [ ] No

Work Phone (2): __________________________ May we leave a message? [ ] Yes or [ ] No

Cell Phone (1):__________________________ May we leave a message? [ ] Yes or [ ] No

Cell Phone (2): _________________________ May we leave a message? [ ] Yes or [ ] No

Are there ethnic/cultural/lifestyle/gender/religious considerations you would like us to be aware of during your care?

If yes, please describe: ____

Please briefly describe the main issues bringing into therapy: ____
____
____
____

Section 1 – Relationship Status

____ Married ____ Separated ____ Divorced ____ Widowed ____ Committed Relationship

* Do you have children? [ ] Yes or [ ] No * Do your children live with you? [ ] Yes or [ ] No

Please indicate gender and ages of your children: ____
____

Please check if any of the following that apply to your relationship:

____ Conflicts Around Household Chores ____Parenting Conflicts ____Financial Issues ____ Lack of Time Together

____ Work-related Conflicts ____ Lack of Socialization ____ Spiritual Differences ____ Lack of Affection

____ Sexual Difficulty ____ History of Infidelity ____ Disrespectful Communication ____ Physical Altercations

____ Blended Family Issues ____ Conflicts with Extended Family / In-laws ____ Substance Abuse Issues

____ Legal Problems ____ Housing Problems ____ Medical Problems

Section 2 A– Employment History (Name) ______________________________________

Current Employment Status:

____ Unemployed ____ Leave of Absence ____ Employed Part Time ____ Employed Full Time

____ Student ____ Temporary Employment

Employer: ____

Position / Title: ______________________________________ Length of Time with Employer: __________

Please Indicate any Problem Areas:

____ Conflict with Co-Worker (s) ____ Conflict with Employer / Supervisor ____ Poor Work Performance

____ Poor Work Performance ____ Absent / Late ____ Inadequate Training / Skills ____ Other

Section 2B – Employment History (Name) ______________________________________

Current Employment Status:

____ Unemployed ____ Leave of Absence ____ Employed Part Time ____ Employed Full Time

____ Student ____ Temporary Employment

Employer: ____

Position / Title: ______________________________________ Length of Time with Employer: __________

Please Indicate any Problem Areas:

____ Conflict with Co-Worker (s) ____ Conflict with Employer / Supervisor ____ Poor Work Performance

____ Poor Work Performance ____ Absent / Late ____ Inadequate Training / Skills ____ Other

Section 3 A – Education (Name) ____

Please check the highest grade level you completed:

____ GED ____ High School Diploma ____BA/BS Degree ____ Some College Course Work Completed

____ Doctorate Degree ____ AA Degree or 2 Year Program Completion ____ Other _________________

Please Indicate any Problem Areas:

____ Difficulty Concentrating ____ Other: ____

____ Inability to Complete Course Work ____ Learning Disability – Please explain: _________________________

Section 3 B – Education (Name) ____

Please check the highest grade level you completed:

____ GED ____ High School Diploma ____BA/BS Degree ____ Some College Course Work Completed

____ Doctorate Degree ____ AA Degree or 2 Year Program Completion ____ Other _________________

Please Indicate any Problem Areas:

____ Difficulty Concentrating ____ Other: ____

____ Inability to Complete Course Work ____ Learning Disability – Please explain: _________________________

Section 4A – Personal History (Name) ____

Before the age of 18 did you ever witness or experience the following (if Yes, please explain):

____ Physical Violence ____ Sexual Abuse ____ Humiliation or Belittling ____ Family Member Chemical Abuse

____ Death of a Loved One ____ Divorce or Separation ____ Family Member Mental Health Symptoms

____
____
____
____

Please describe the family you grew up in: ____
____
____
____

Section 4B – Personal History (Name) ____

Before the age of 18 did you ever witness or experience the following (if Yes, please explain):

____ Physical Violence ____ Sexual Abuse ____ Humiliation or Belittling ____ Family Member Chemical Abuse

____ Death of a Loved One ____ Divorce or Separation ____ Family Member Mental Health Symptoms

____
____
____
____

Please describe the family you grew up in: ____
____
____
____

Section 5A – Personal Concerns (Name) ____

Please check any of the following that apply to yourself:

____ Depression ____ Impulsivity ____Gambling ____Panic Attacks ____ Mood Swings

____ Low Self Esteem ____ Hallucinations ____ Anger Issues ____ Eating Problems/Disorder

____ Suicidal Thoughts / Suicide Attempt(s) ____ Self Injury ____ Uncomfortable in Social Situation

____ Difficulty Concentrating ____ Sexual Difficulty ____ Anxiety / Worry / Nervousness

____ Alcohol/Substance Abuse/Dependence ____ Other (explain) _____________________________________

Section 5B – Personal Concerns (Name) ____

Please check any of the following that apply to yourself:

____ Depression ____ Impulsivity ____Gambling ____Panic Attacks ____ Mood Swings

____ Low Self Esteem ____ Hallucinations ____ Anger Issues ____ Eating Problems/Disorder

____ Suicidal Thoughts / Suicide Attempt(s) ____ Self Injury ____ Uncomfortable in Social Situation

____ Difficulty Concentrating ____ Sexual Difficulty ____ Anxiety / Worry / Nervousness

____ Alcohol/Substance Abuse/Dependence ____ Other (explain) _____________________________________

Section 6A – Chemical Health (Name) ____

Please answer the following questions honestly.

Question	Yes	No	Explain
Do you smoke?			**If yes, how much?**
Do you drink alcohol?			**If yes, how much?**
Number of drinks per time? _____________			**Last use?**
Have you felt you ought to cut down on your drinking or drug use?			
Have you felt bad or guilty about your drinking or drug use?			
Have you ever had a drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?			

Please indicate the date of **LAST USE** of the following chemicals.

Chemical Type	Date Last Used
Cocaine	
Marijuana	
Sleeping Pills	
Heroin	
Stimulants/Pep Pills/ Diet Pills	
Tranquilizers/Acid/Angel Dust/LSD	
Pain Pills/Amphetamines/Methamphetamines	
Other ______________________________	

Below please list names and dates of any chemical dependency treatment programs

Section 6B – Chemical Health (Name) ____

Please answer the following questions honestly.

Question	Yes	No	Explain
Do you smoke?			**If yes, how much?**
Do you drink alcohol?			**If yes, how much?**
Number of drinks per time? _____________			**Last use?**
Have you felt you ought to cut down on your drinking or drug use?			
Have you felt bad or guilty about your drinking or drug use?			
Have you ever had a drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?			

Please indicate the date of **LAST USE** of the following chemicals.

Chemical Type	Date Last Used
Cocaine	
Marijuana	
Sleeping Pills	
Heroin	
Stimulants/Pep Pills/ Diet Pills	
Tranquilizers/Acid/Angel Dust/LSD	
Pain Pills/Amphetamines/Methamphetamines	
Other ______________________________	

Below please list names and dates of any chemical dependency treatment programs

Section 7A – Medical Information (Name) ____

Name of primary care physician or medical group: ____

Approximate date you last saw your / a physician: ____

Please list all the prescription medications you are currently taking: ____
____
____

Please list other over the counter medications you regularly take (aspirin, laxatives, vitamins, supplements and herbal remedies): ____

Please check if you have been treated for any of the following:

____ High Blood Pressure ____ Tuberculosis ____ Diabetes ____Stroke ____Thyroid Problem

____ Meningitis ____ Heart Problem ____ Ulcers ____ Hepatitis ____ Seizures

____ Cancer ____ Organic Brain Dysfunction ____ Allergies (specify):

Please list any other medical conditions we should be aware of (surgeries, auto accident injuries, etc): _______________
____
____

Please indicate any physical symptoms you have:

____ Excessive Fatigue / Energy ____ Dizziness ____ Too Much / Too Little Sleep ____ Poor Hygiene

____ Loss of Appetite / Anorexia / Binge Eating ____ Headaches ____ Little or No Exercise

____ Pain (specify): ________________________ Other:____

Section 7B – Medical Information (Name) ____

Name of primary care physician or medical group: ____

Approximate date you last saw your / a physician: ____

Please list all the prescription medications you are currently taking: ____
____
____

Please list other over the counter medications you regularly take (aspirin, laxatives, vitamins, supplements and herbal remedies): ____

Please check if you have been treated for any of the following:

____ High Blood Pressure ____ Tuberculosis ____ Diabetes ____Stroke ____Thyroid Problem

____ Meningitis ____ Heart Problem ____ Ulcers ____ Hepatitis ____ Seizures

____ Cancer ____ Organic Brain Dysfunction ____ Allergies (specify):

Please list any other medical conditions we should be aware of (surgeries, auto accident injuries, etc): _______________
____
____

Please indicate any physical symptoms you have:

____ Excessive Fatigue / Energy ____ Dizziness ____ Too Much / Too Little Sleep ____ Poor Hygiene

____ Loss of Appetite / Anorexia / Binge Eating ____ Headaches ____ Little or No Exercise

____ Pain (specify): ________________________ Other:____

Section 8A – Previous Mental Health Services (Name) ____

Name of current Psychiatrist / Clinic: ____

Name of County Social Worker: ____

Prior Psychiatrist: ____ Years Treated: ________

- Medications: ____
- Date of most recent psychiatric hospitalization: ______________ Hospital Name: _________________________
- Approximate number of psychiatric hospitalizations: ____

Prior Therapist: ____ Years Treated: ________

- Issues: ____

Your Child's Therapist: ____ Years Treated: ________

- Issues: ____

Please list any other background information you feel may be helpful to the therapist in understanding you: ____________
____

Section 8B – Previous Mental Health Services (Name) ____

Name of current Psychiatrist / Clinic: ____

Name of County Social Worker: ____

Prior Psychiatrist: ____ Years Treated: ________

- Medications: ____
- Date of most recent psychiatric hospitalization: ______________ Hospital Name: _________________________
- Approximate number of psychiatric hospitalizations: ____

Prior Therapist: ____ Years Treated: ________

- Issues: ____

Your Child's Therapist: ____ Years Treated: ________

- Issues: ____

Please list any other background information you feel may be helpful to the therapist in understanding you: ____________
____