Name: (A)_____ DOB_____

Name: (B)_____ DOB_____

Date: ___/_____/_____

INITIAL COUPLES ASSESSMENT/CONSULTATION

Please answer the following questions together truthfully and complete as possible. Your answers will help your individualized treatment planning or consultation (if applicable) at **Chat N Relax Counseling & Consultation, LLC**.

TREATMENT_____

1. **Please explain the reason(s) for your visit.**

(A)	**(B)**
_____	_____
_____	_____
_____	_____
_____	_____

2. **Please list any previous couples counseling, mental health, and/or substance use treatment. (Location/Year)**

(A)_____ _____ (Year/s)

(B)_____ _____ (Year/s)

(A+B)_____ _____ (Year/s)

3. **Have either of you ever had thoughts of suicide? If yes, when?**
   (A) Y or N _____ **(B)** Y or N _____
4. **Have either you ever had any previous attempts or plans of suicide? If yes, please explain. (A)** Y or N _____ **(B)** Y or N_____
5. **Have either you ever had thoughts or plans to hurt or harm others? If yes, please explain. (A)** Y or N _____ **(B)** Y or N_____
6. **Any past physical, emotional, or mental trauma history experienced by either of you that has significantly impacted your mental health? If yes, please explain**: **(A)** Y or N _____ **(B)** Y or N_____

Name: (A)_____ DOB_____

Name: (B)_____ DOB_____

Date: ___/_____/_____

INITIAL COUPLES ASSESSMENT/CONSULTATION

7. **Have either of you ever been <u>screened or hospitalized for a mental health or psychiatric concern</u>? Y or N If yes, please provide hospital information.**

HOSPITAL		YEAR		REASON	
(A)	**(B)**	**(A)**	**(B)**	**(A)**	**(B)**

8. ***Please circle any of the following that may have affected the relationship:***

Depression Anxiety Sadness Anger Lack of Communication Lack of Support Abuse

Thoughts of hurting self Thoughts of hurting others Physical Fighting Violence

Law Enforcement Moodiness Infidelity Attempted Suicide Drugs Trauma Grief

Transitional/Adjustment Consistent/Repetitive Arguments Intimacy Issues/Concerns

Other: _____

EDUCATION_____

9. **High School Graduates? (A) Y or N _____ / (B) Y or N _____**
10. **College Graduates? (A) Y or N _____ / (B) Y or N _____**

EMPLOYMENT _____

11. **Full time Work? (A) Y or N_____**

(B) Y or N _____

Name: (A)_____ DOB_____

Name: (B)_____ DOB_____

Date: ___/_____/_____

INITIAL COUPLES ASSESSMENT/CONSULTATION

12. Part time Work? (A) Y or N_____

(B) Y or N _____

FAMILY LIFE & HISTORY_____

13. Status of Relationship: ___Dating ___Married ___Separated ___Other:_____

14. Who lives with you? (A)_____ (B)_____

15. Any children? (A) _____ (B)_____

16. Active positive social life? (A) Y or N _____ / (B) Y or N _____

17. Able to maintain healthy relationships in life? (A) Y or N _____

(B) Y or N _____

18. Any history of: **Emotional** Abuse **(A)** Y or N / **(B)** Y or N

Verbal Abuse **(A)** Y or N / **(B)** Y or N

Physical Abuse **(A)** Y or N / **(B)** Y or N

Sexual Abuse **(A)** Y or N / **(B)** Y or N

Discriminatory/Neglect Abuse **(A)** Y or N / **(B)** Y or N

19. Any general comment or statement about your family life and how it affects your relationship?

(A)_____(B)_____

MEDICAL HISTORY_____

20. Any general medical conditions, diagnoses or allergies? (A) Y or N _____

(B) Y or N _____

21. Any medical condition(s) related to substance use/abuse? (A) Y or N _____

(B) Y or N _____

22. Any physical, mental, or learning disabilities? (A) Y or N _____

(B) Y or N _____

Name: (A)_____ DOB_____

Name: (B)_____ DOB_____

Date: ___/_____/_____

INITIAL COUPLES ASSESSMENT/CONSULTATION

23. Primary Doctor? (A) _____ (B) _____

24. Are you taking any prescribed medications? (A) Y or N / (B) Y or N

MEDICATION	DOSAGE	FOR	DOCTOR
(A)			
(B)			

25. Describe your appetite. (A) _____ (B) _____

26. Describe your sleeping. (A) _____ (B) _____

27. Describe your intimacy engagement or perception about it.

(A) _____(B) _____

SUBSTANCE USE HISTORY_____

28. Please indicate (A) & (B)s substance use history below (if applicable):

SUBSTANCE	AGE 1st use	Amount	Frequency	Last Use	Route
Alcohol					
Amphetamines					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Ecstasy					
Hallucinogens					
Heroin					

Name: (A)_____ DOB_____

Name: (B)_____ DOB_____

Date: ___/_____/_____

INITIAL COUPLES ASSESSMENT/CONSULTATION

Inhalants					
K2/Spice					
Ketamine					
Methamphetamine					
Methadone					
Other Opiates					
Other Sedatives					
OTHER_____					
Over the Counter					

29. Any history of overdose? (A) Y or N / **(B**) Y or N

30. Any history of previous substance use treatment? (A) Y or N / **(B**) Y or N

LEGAL_____

31. Any current or pending legal issues, court cases, or charges? Including DCP&P?

(A) Y or N _____ / (B) Y or N _____

32. Probation/Parole? (A) Y or N _____ / (B) Y or N _____

33. In possession of an Advance Medical or Psychiatric Directive?

(A) Y or N _____ / (B) Y or N _____

GOALS_____

34. Goals to accomplish in counseling?

(A)_____

(B)_____

Name: (A)_____ DOB_____

Name: (B)_____ DOB_____

Date: ___/_____/_____

INITIAL COUPLES ASSESSMENT/CONSULTATION

By signing below, I acknowledge my answers are truthful and recalled to the best of my knowledge.

_____ _____

(Client Signature -**A**) (Date)

By signing below, I acknowledge my answers are truthful and recalled to the best of my knowledge.

_____ _____

(Client Signature -**B**) (Date)