

Couples Therapy Supplemental Questionnaire

(Please complete this questionnaire independent of your partner)

Date: _____

Your Name: _____

Partner's Name: _____

Status (*circle one*): Engaged Married/Partnered Separated Divorced Live Together

How long have you been in this relationship? _____

If living together, how long did you date before cohabiting?

*List any previous marriages and long-term relationships

Approximate Dates

Status (i.e., divorced, friends)

Children (name/age)

What concerns or problems have led you to seek couple therapy?

About Your Relationship

What was the very beginning of your relationship like?

What first attracted you to your partner?

How did your relationship change over time?

What is the worst thing you have dealt with in your relationship?

How do you typically handle conflict with your partner?

What did your parents model for you about marriage and how people relate to each other?

How open are you in expressing your wants, thoughts, desires and feelings to your partner? On a scale of 1 to 10 (*1 is totally closed and 10 is totally open*)._____

Describe your level of commitment to your relationship, on a scale of 1 to 10 (*1=not at all and 10=extremely*). Explain the rating that you give yourself?

How would you describe your sexual relationship?

What is one thing that you wish was different about your sexual relationship?

When do you feel most gratified in your relationship?

What do you feel are your biggest strengths as a couple?

What do you feel are your biggest weaknesses as a couple?

What role have you played in contributing to the problems in your relationship?

What do you hope to accomplish through counselling?
