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Couple History Form
(Each partner to complete separately)

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Biological Sex: _____

Identified Gender (if different than sex): _____

Preferred Gender Pronouns (if applicable): _____

Sexual Orientation: _____ Partner/Relationship Status:_____

Race/Ethnicity: _____ Religious/Spiritual Affiliation: _____

Other Important Cultural Information: _____

This form, along with your partner's Couple History Form, will be used during your intake session to guide the initial assessment process and make the most of our first session together.

Presenting Problem:
What brings you in for couples therapy at this point?:

How do you see the problem(s) in the relationship?:

Current Relationship Dynamics:
What are your relationship strengths?:

How the two of you communicate about the following:
Day to day information (i.e. work, household tasks, plans)

When there is disagreement:

Issues related to your children/parenting (if applicable):

Sex:

Please describe any current stressors that may be affecting your relationship:

Relationship History:

How did you meet your partner?:

How long were you together before you first became seriously committed to each other?:

What first attracted you about your partner and are those qualities still present?:

What did you like best/least about your partner?:

When did your relationship change and what occurred around that time?:

Have there been any relationship betrayals? If so, please explain:

Please describe any past stressors that could have affected your relationship:

Sexual Orientation:
Please describe your sexual orientation:

Please describe your coming out history (if applicable):

Sexual Relationship History:
When was your first sexual encounter with each other? Please describe this experience:

What is your sex life like now? Please describe frequency ***and*** quality of sex:

Please circle/highlight any specific sexual difficulties that are occurring:
Low desire *Low arousal* *Difficulty reaching orgasm* *Premature/rapid ejaculation*

Delayed ejaculation *Pain with vaginal penetration* *Pain with anal penetration*

Discrepancies in level of sexual desire with your partner *Sexual avoidance*

Feelings of embarrassment talking about sex with a partner

Are there any other sexual concerns you might want to discuss with Dr. Hanzlik? Y/N
(Feel free to write those below or wait until face to face session to discuss)

INDIVIDUAL HISTORY

This section includes information about you, individually, that may contribute to some struggles you are experiencing as a couple.

Mental Health History:
Please list any current mental health symptoms you may be experiencing:

How long have you been dealing with these concerns?:

Please list past outpatient therapy you may have received:
(Name of therapist/length of time in therapy/type of work completed/past diagnoses)

Please list past inpatient mental health hospitalization you may have received:
(Name of hospital/location/length of stay/age of hospitalization/reason for hospitalization)

Please list past and current medications you have been prescribed/are using:

Medication name	Dosage	Reason for med.	Taking as prescribed? (Y/N)

Educational History:
Highest level of education/name of school:

Please list/describe any trouble you may have experienced in school (academic or behavioral)?:

Employment History:
Occupation:
Place of employment:
Have you ever been fired from a position? Y/N
If Yes, what were the circumstances?:

Military Status (circle all that apply)
Branch of military served:
Currently enlisted
Reserves
Veteran-Discharge Status/Reason for discharge:
Honorable
Other Than Honorable Conditions
Bad Conduct
Dishonorable
Officer
Entry-level separation
Medical
Administrative
Tours of duty completed:

Social Functioning:
Who do you rely on for support?:

What do you do for fun?:
As a couple *As an individual*

Medical History:
Please list any medical conditions you have and rate how well managed they are (good, fair, poor):

Please list any surgeries you may have had:

Please list any hospitalizations you may have had for a medical condition/length of stay:

Family of Origin History:
Place of birth:

By whom were you raised?:

Relationships with family members (e.g. good, fair, poor, abusive, no contact):
(QoR=Quality of Relationship)

Name	Relationship	Past QoR	Current QoR	Mental Health Symptoms/Diagnoses

Please list other family members not listed above who may have had diagnosed or undiagnosed mental health conditions:

Please describe your parents' relationship (connected/loving/conflictual/violent). How did they handle conflict?

Please list any other significant attachment figures in your life growing up:

How was sex communicated about in your family of origin?:

Trauma History

The purpose of this section is for me to have a better understanding if there have been past experiences of trauma on your part that may be affecting you in the present. We can discuss this section in more detail when we meet in person.

Please circle/highlight any of the following you may have experienced:

Physical abuse *Emotional/verbal abuse* *Sexual abuse*

Witnessing violence (including domestic violence) *Bullying*

Confusing experiences/boundary violations *Peer rejection*

Natural disasters *Loss of a parent or other important caregiver*

Substance Use:

Please check the following substances you have used in the past and currently:

	Past	Current
Alcohol		
Wine		
Liquor		
Beer		
Marijuana (any form)		
Cocaine		
Crack Cocaine		
Hallucinogens		
Inhalants		
"Club Drugs" (i.e. Ecstasy)		
Heroin		
Prescription Drugs (not as prescribed)		
Stimulants		
Tobacco		
Caffeine		
Other		

Has anyone ever expressed concern that you might need to cut back on your use? (Y/N/Who/Circumstances):

If so, have you felt annoyed/irritated and has it caused conflict?:

Please list any prior treatment for drug or alcohol use:
(Inpatient/Intensive Outpatient/Educational/Detox/Date/Location):

Legal History:

Charge	Date of Arrest	Incarcerated (Y/N)	Pending Case (Y/N)

Wrap-Up:

What are you strengths as a couple?:

1.

2.

3.

What are your vulnerabilities or challenges as a couple?:

1.

2.

3.

What are 3 changes you would ask of and/or want from your partner?

1.

2.

3.

Other Important Information Dr. Hanzlik Should Know About:

Goals for couples therapy:

Short-Term	Long-Term
1.	1.
2.	2.
3.	3.