Lifeline Counseling LLC

Couples Questionnaire

Date: ___________ *If possible, each individual should complete his/her own form.*

Name: ____ age: _______

Partner's Name: ______________________________________ age: _______

Relationship status: ____ single ____ engaged ____ married: # of years _______

____ separated ____ divorced ____ other: _________________________

Children (list names/ages): ____

____

Have you been married previously? _____ Yes: # of years ______________________________

Has your partner been married previously? ____ Yes: # of years _________________________

History

What problems or concerns have you come here to address? ____________________________

____

____

____

Have you seen a counselor before? If so, who/when? __________________________________

____

Did you find it helpful? ____

____

Have you/your partner threatened, physically restrained, used violence, or injured the other person in this relationship? _____ Yes: if so, please describe (who, when, what occurred) ____

____

____

Have you/your partner engaged in a physical or emotional affair, or used pornography while in this relationship? _____ Yes: if yes, please identify the nature and frequency of the behavior __

____

____

Have you/your partner threatened to separate or divorce? ____ Yes: if yes, please describe_____

____

____

Do you/your partner have a military history? ____ Yes: if yes, please describe ______________

____

Do you/your partner have any legal issues? ____ Yes: if yes, please describe ______________

____

____

Do you/your partner drink alcohol or use drugs to intoxication? _________________________

Are you having financial problems? ____

Biopsychosocial History

Do you have any medical conditions? ____ Yes: if yes please indicate ___________________

____

____

Do you currently have a psychiatrist? ____ Yes: If yes, when was the last appointment? _____

_______________________ When is next appointment? _______________________________

Please list any medications you currently take: _______________________________________

____

____

Do you/your partner have a history of mental illness, substance abuse, or eating disorder? If yes, please indicate: ____

____

____

Does anyone in your extended family have a history of mental illness, substance abuse, or eating disorder? If yes, please indicate: ____

____

____

Do you have any history of childhood trauma or abuse? ________________________________

____

Have you ever attempted suicide? If yes, please indicate date/means ____________________

____

Have you ever been hospitalized psychiatrically? If yes, please indicate when and where ______

____

Have you ever felt like seriously hurting someone? If yes, please explain _________________

____

Statement of confidentiality

The personal information shared in this consult and/or therapy session will be kept confidential or private within the boundaries of the law and by what are considered best practices of the field. Information will not be shared beyond without written consent of the client or legal guardian/parent, except where mandated by law or legal precedent for safety factors, including where there is a danger of harm to self or others.

Mandated Reporters

State law mandates certain professionals or officials, acting in their professional capacity, must report concerns about any child or disabled/impaired adult who may be, or is at risk of being, abused or neglected. Most mandated reporters work in schools, health care, counseling/psychology, child care, camps for children, the legal field, social work, or developmental disability programs. More specific information on mandated reporters, and a complete list, is available at Ohio Revised Code 2151.421.

Consent to treat

I consent to participate in the proposed treatment as recommended by the provider in accordance with the standards of professional practice. I hereby certify that the clinician has informed me of his/her professional qualifications, certifications, and/or licensure.

Assignment of Benefits and Release of information

I hereby assign, transfer, and set over to Lifeline Counseling LLC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I authorize Lifeline Counseling LLC to release by financial information to my guarantor or third party collection agency if further collection assistance is required.

____ __________
client sign date

____ __________
counselor/witness sign date