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Comprehensive Marital Therapy Intake Questionnaire

This questionnaire will help me best understand your current difficulties as well as your past history. Please fill out this questionnaire to the best of your ability **before** your intake appointment and bring it with you. Read the questions carefully and answer them as fully as possible (use the reverse side of the paper if necessary). If there are questions that you don't understand, please mark them with a star (*) and Dr. Aviv will review them with you at the intake appointment. Many of the questions are designated self and spouse…please be consistent. One of you should complete as self; and the other as spouse. DO NOT ANSWER FOR EACH OTHER.

Personal Information

Date: _____

Name _____ **Date of Birth:** _____

Spouse _____ **Date of Birth:** _____

Home address: _____

Telephone Numbers (Self): _____ (H) _____(W) _____(C)

Telephone Numbers (Spouse) _____ (H) _____(W) _____(C)

Email _____

	Self	**Spouse**
Psychiatric Diagnoses (Past and Present)		
Current Medications		

Are you employed? _____Yes _____No (if yes, specify how long job held and # hours/week)

Is your spouse employed? _____Yes _____No (if yes, specify how long job held and # hours/week)

What problems or questions have caused you to seek help at this time?
Do you and your spouse agree about the difficulties? Does each person want to obtain help?

Family History

1. **Please complete the following information regarding in the appropriate column:**

	Self	Spouse
Age		
Highest Level of Education Completed		
Degrees/Diplomas		
Current Occupation		
Describe any special education or tutoring received		
Any diagnosed learning difficulties? If so in what subjects?		
Any psychological or psychiatric problem for which treatment was received?		
Any Attention Deficit Disorder (with or without Hyperactivity?)		

2. **Children in the family**

Name	Gender	Age	In home?	Social/Behavioral/Health problems? List

3. **Please provide any information about each of your extended families that might help me understand your needs (medical, behavioral, psychological, educational, and emotional):**

4. **Is there any significant medical history for you or your spouse?**

5. **The following table is designed to assess your and your spouse's ability to relate to others. Check all that apply**

	Self	**Spouse**
Do you have difficulty relating to others?		
Do you verbally argue a lot with others?		
Do you have difficulty making friends?		
Do you have difficulty maintaining friendships?		
Do you have at least one good friend?		
Are your invited to friend's houses?		
Do you like to host others at your house?		
Do you have a small group of good friends?		
Do you prefer to be alone?		
Do your have difficulty with the non-verbal rules of social interaction (e.g. turn taking, how close to stand to others)		
Do you like your spouse's friends?		

6. Add any comments about your social circumstances that are relevant:

7. Please each answer the following questions

Question	Self	Spouse
What time do you go to bed?		
What time do you get up?		
Is your sleep consistent?		
Are you concerned that you don't get enough sleep and/or have poor sleep quality?		

8. Rate your alcohol use?

Self: _____ Never _____ Occasionally (1x/week or less) ____2-4x/week ____Daily
Spouse: _____ Never _____ Occasionally (1x/week or less) ____2-4x/week ____Daily

9. Rate your drug use?

Self: _____ Never _____ Occasionally (1x/week or less) ____2-4x/week ____Daily
Spouse: _____ Never _____ Occasionally (1x/week or less) ____2-4x/week ____Daily

10. List all drugs you have tried

Self	Spouse

11. Work History: Please indicate below all major jobs/careers you have held. List the job title and amount of time spent working in this position.

Self	Spouse
1.	
2.	
3.	
4.	
5.	
6.	
7.	

12. Please put a check for the traits/characteristics below which apply to yourself as central traits/characteristics:

Trait	**Self**	**Spouse**
Happy		
Friendly		
Independent		
Affectionate		
Sensitive		
Thoughtful		
Cooperative		
Responsible		
Even tempered		
Sad		
Moody		
Quiet		
Overactive		
Dependent		
Fearful		
Impulsive		
Angry		
Short attention span		
Explosive		
Withdrawn		
Dreamer		
Lethargic		
Difficulty calming down		
Over-reactive		
Lacking in self-control		
Withholding of affection		
Volatile		
Other words of your choosing:		

13. Please describe any major family stressors that may have impacted you in the past or that may impact you now:

14. Are there any particularly traumatic or troubling events which have happened in your life which I should know about in order to understand you better? (please give details, include incidents you feel were traumatic even though they might not have been for someone else)

15. Are you and your spouse currently intimate with each other? ____Yes ____No

16. Are each of you satisfied with you sex life?
Self: ___Yes ____No
Spouse: ___Yes ____No

17. If no (to 16), what would you like to be different?

18. Have you ever witnessed violence inside or outside of the home? Yes____ No____

19. Have either of you ever had psychological counseling or therapy?
____ Yes, If Yes, please give details below: ____ No

Therapist Name	**Address**	**Phone Number**	**Dates of treatment**

20. Please list the names, addresses, and telephone numbers of any other professionals consulted. (This does not give me permission to contact them, and they will only be contacted with your written consent.)

21. Is there any additional information or anything that you feel is pertinent to know that has not been covered in this questionnaire?

22. What changes do you hope will result from seeking psychological services?

23. Who referred you to Dr. Aviv's clinic?