Douglas Tilley, LCSW-C
107 Chautaugua Rd
Arnold, MD 21012

CLIENT DATA AND CONTACT INFORMATION

NAME: _____DATE:_____

DOB_____AGE_____

Who referred you? _____

I give my permission to be contacted by the means listed below:

Mailing Address _____

_____

Phone: home _____

Phone: work _____

Phone: cell _____

Email_____

Signature: _____

Couple Screening Form

Name:_____Date:_____

Directions: ✔ ***Check the items that apply***

MOODS: (ex. irritability, depression etc.)

____My moods are a problem to the relationship. how?:

____My partner's moods are a problem to the relationship. how?:

ALCOHOL and SUBSTANCE USE

____My use of alcohol is excessive
____My use of prescription or illegal drugs is a problem

____My partner's uses alcohol excessively
____My partner's use of prescription or illegal drugs is a problem

AGGRESSION

____My temper adversely affects our relationship
____I have been verbally abusive to my partner
____I have been physically abusive to my partner

____My partner's temper adversely affects our relationship
____My partner has been verbally abusive to me
____My partner has been physically abusive to me

____Our fights and arguments are very destructive to our relationship.

AFFAIRS

____I have had an affair during our relationship (or an inappropriate outside relationship).

____I am currently having an affair (or an inappropriate outside relationship).

____My partner has had an affair during our relationship (or an inappropriate relationship)

____My partner is currently having an affair or an inappropriate outside relationship).

***Name*_____**

When you are not getting along, how do you feel?

How strongly do you agree with the statements below.
Use this scale to answer the questions.

0	25%	50%	75%	100%
Not at all	Slightly	Moderately	Very	Extremely

_____% I feel disorganized by all this negative emotion.

_____% I can't think straight when my partner gets so negative.

_____% Talking things over with my partner only seems to make them worse.

_____% I have little confidence that we can discuss a significant problem without fighting.

_____% I am basically unhappy with my relationship.

_____% I have often felt like leaving my partner.

_____% I often don't feel close to my partner.

_____% I'm not satisfied with our sex life.

_____% I feel lonely in our relationship.

_____% I feel we are disconnected.

_____% My partner and I live pretty separate lives.

_____% I confide in a special person outside of our relationship. Who?

_____% There are specific events in our relationship which I am having trouble getting over. What?

_____% In spite of all our problems, I believe that my partner really cares about me.

Name _____ Date: _____

COUPLE SATISFACTION CHECKLIST

✓ Place a check in the box to the right of each relationship category that best describes **how satisfied you feel**.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	✓ Check Areas You Want Most to Change
1. Degree of Closeness, Openness, Confiding, Sharing and Comforting							
2. Expression of Affection and Caring							
3. Satisfaction with Sexual Intimacy							
4. Handling Conflicts and Arguments							
5. Expression of Anger, Criticism or Blame							
6. Handling Family Finances							
7. Handling of Parenting Issues							
8. Handling of Household Tasks							
9. Common Interests and Social Life							
10. Degree of Respect and Admiration for Your Partner							
11. Satisfaction with Your Role in the Relationship							
12. Satisfaction with Your Partner's Role in the Relationship							

_____% Over all how satisfied are you with your relationship

_____% I am committed to staying in our relationship

Name_____

My Goals for Couple Therapy

1. **_____**
2. **_____**
3. **_____**

In this space, please share any additional information that you think I should know ……..

Name:_____ Date:_____

INDIVIDUAL PROBLEM CHECK LIST

Directions: ***Put a number next to any item which you experience.*** **1=mildly, 2=moderately, 3=severely**

Emotional Concerns
____feeling generally anxious or nervous
____feeling panicky
____dwelling on certain thoughts or images
____having strong fears
____feeling out of control
____avoiding being with people
____fears of being alone or abandoned
____having nightmares
____flashbacks
____troubling or painful memories
____feeling numb instead of upset
____feeling depressed or sad
____being tired or lacking energy
____feeling unmotivated
____loss of interest in many things
____having trouble concentrating
____having trouble making decisions
____feeling the future looks hopeless
____feeling worthless or a failure
____feeling self critical or blaming yourself
____thoughts of hurting yourself
____feeling resentful or angry
____feeling irritable or frustrated
____feeling rage
____feeling like hurting someone

_____

Behavioral and Physical Concerns
____not having an appetite
____eating in binges
____self induced vomiting for weight control
____often spending in binges
____engaging in risky behaviors
____temper outbursts
____impulsive reactions
____trouble being organized
____trouble finishing things
____using alcohol too much
____being alcoholic
____using drugs
____driving under the influence
____blackouts - after drinking

_____

Intimate Relationship Concerns
____not feeling close to partner
____trouble communicating with partner
____not trusting partner
____lack of respect by partner
____partner being secretive
____lack of fairness in relationship
____lack of affection
____unsatisfactory sexual relationship
____frequent arguments
____partner being demanding and controlling
____violent arguments
____wanting to separate
____disagreeing about children
____children having special needs
____problems with in-laws
____problems with ex-partner
____problems with step parents

_____

Sexual Concerns
____feeling a lack of sexual desire
____feeling neglected sexually
____feeling used sexually
____issues with orgasms or erections
____feeling negatively about sex

_____

When Growing Up to Present Time:
____being physically abused - by whom?
____being emotionally abused - by whom?
____being sexually abused - by whom?
____having an alcoholic parent - which?
____having a drug abusing parent - which?
____having a depressed parent - which?
____having parents separate or divorce
____close family member dying - who?
____felt neglected or unloved - by whom
____having an unhappy childhood
____having serious medical problems - what?
____having drug or alcohol problem
____having learning problems - what?
____having attempted suicide - when?

_____

Stresses During the Past Several Years:

____death of family member or friend - who?
____self or family member hospitalized - who?
____moved
____being harassed or assaulted
____separation/divorce
____losing or changing job
____financial trouble
____legal problems
____natural disaster
____other _____

_____

Life Style and Health

____losing weight - how much?_____
____gaining weight - how much?____
____trouble sleeping
____# of hours I usually sleep: _____
____smoking cigarettes
____lack of exercise
____not having leisure activities
____serious or chronic illness -what: _____