

Couples Health Assessment

Name: _____ Date of Birth: _____ Today's Date: _____

Zip Code: _____ County: _____ State: _____

In what year and month did you last test for Gonorrhea and/or Chlamydia?

Month: _____ Year: _____

In what year and month did you last test for Syphilis?

Month: _____ Year: _____

Do you feel your partner forced you to test together?

No Yes

How often does your partner...	Never	Rarely	Sometimes	Often	Very Often
...insult, talk down, or scream at you?	<input type="checkbox"/>				
...threaten or physically hurt you?	<input type="checkbox"/>				
...use words or physical action to force you to have sex?	<input type="checkbox"/>				

In your relationship, how often do you plan to discuss...	Never	Rarely	Sometimes	Often	Very Often
...condom use?	<input type="checkbox"/>				
...monogamy vs non-monogamy?	<input type="checkbox"/>				
...testing for HIV and other STIs?	<input type="checkbox"/>				

What specific question or concern would you like to address about HIV/STIs in your relationship?
