_____ Church
Marriage Counseling

Please Note: All information is kept confidential. You should receive a call to schedule an appointment from someone within 7 days upon return of this form.

Date: _____

Full Name: _____

Gender: ☐ Male ☐ Female

Birth Date: ___/___/____ Age: ____

Address: _____
City, State & Zip: _____

Email: _____

Primary Contact Number: (____) _____

Vocation: _____

Current Living Situation: _____

Personal Experience with Jesus

Are you a member of _____ Church? ☐ Yes ☐ No

How long have you been a member? _____

Where do you serve? _____

Have you taken any classes on marriage? ☐ Yes ☐ No

If you aren't a member here, which church do you attend and how are you involved?

_____

_____

Marital Status

Marital Status ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

If separated, widowed, or divorced, how long? _____

If married, your spouse's name: _____

How long have you been married? _____

Have you received pre-marriage counseling? ☐ Yes ☐ No

Have you participated in a pre-marriage class? ☐ Yes ☐ No

If you've been married previously, how long? _____

If you have children, please complete this section:

Child 1 Full Name: _____ ☐ Male ☐ Female Age: _____

Child 2 Full Name: _____ ☐ Male ☐ Female Age: _____

Child 3 Full Name: _____ ☐ Male ☐ Female Age: _____

Child 4 Full Name: _____ ☐ Male ☐ Female Age: _____

Child 5 Full Name: _____ ☐ Male ☐ Female Age: _____

Child 6 Full Name: _____ ☐ Male ☐ Female Age: _____

Emotional Status

Emotionally, I often do you struggle with: ☐ Anger ☐ Depression ☐ Fear ☐ Suicide ☐ Mood Swings ☐ Anxiety Attacks ☐ Breakdowns ☐ Confusion

Other emotional issues: _____

_____

Have you had any previous, or present, counseling? ☐ Yes ☐ No
If yes, what was the counsel given? _____

Are you in a doctor's care for any physical or emotional issues? ☐ Yes ☐ No
With whom and for what? _____

_____

Do you take any medications? ☐ Yes ☐ No
If so, please list: _____

_____

Have you ever been in a mental or psychiatric facility? ☐ Yes ☐ No
If yes, for what reason(s): _____

_____

Family History

Who parented you during your early childhood and adolescent years? _____
Describe the emotional climate of your family life: _____

_____

Do you have blank/gap periods in your memories growing up? ☐ Yes ☐ No
Describe any family alcohol and/or drug use: _____

_____

Parents: ☐ Married ☐ Divorced ☐ Separated
If applicable, how did the divorce/separation happen and what age where you? _____

_____

_____

Legal/Social

Have you ever been arrested, charged, or convicted for any criminal offense? ☐ Yes ☐ No
If yes, what? _____

Have you ever been refused entrance into a group or organization? ☐ Yes ☐ No
If yes, why? _____

Have you ever (or currently) used alcohol? ☐ Yes ☐ No
If yes, frequency? _____

Areas of Past and Present Struggle

Check if you have experienced these even once: ☐ Pornography via Media, Phone or Internet
How often? ☐ Now ☐ Worst

☐ Self-Injury/Abuse:

☐ Anorexia/Bulimia/Compulsive Over-Eating: ☐ Co-Dependency ☐ Compulsive Sexual Behavior/Promiscuity ☐ confusion/Insecurity in Gender ☐ Emotional Dependency ☐ Sexual Addiction ☐ Unwanted Fantasies ☐ History of Verbal Abuse ☐ Occult Affiliations ☐ Prescription Drug Abuse ☐ Illegal Drug Abuse ☐ History of Sexual Abuse – By whom (relationship)? _____
What ages? _____ What did you do? _____

Please give a brief explanation as to why you are requesting counseling today: _____
_____
_____

What do you wish to gain from this counseling session? _____
_____
_____

Submit this form to _____ at _____
If you have any questions regarding this form you can call _____ at (___) _____.