Bridges Counseling

A Place for Hope and Restoration

Pre-marital Counseling

Client Personal Data

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date_____ **Referred By**_____

Client Name: _____ Male ❑ Female ❑

Address_____ City_____ Zip Code_____

Home Phone(_____)_____ Cell Phone(____)_____Work Phone(_____)_____

May we call you at home? Y ❑ N ❑ At Work? Y ❑ N ❑

Age_____ Birthdate_____ Highest Grade Completed/Degree_____

Occupation_____

Employer: _____ How Long?_____

Employer Address: _____

Ethnicity: _____ Marital status – current: Single ❑ Divorced ❑ Widow/er ❑

Do you have any children: Yes ❑ No ❑ Are your children living with you? Yes ❑ No ❑

If yes, please list names and ages:_____

NOTE: *It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.* Would you like spirituality/religious issues to be a part of your pre-marital therapy?

Y ❑ N ❑ Don't Know ❑ Church Affiliation (if any)_____

Are you a missionary or on staff at a church?_____

Person to notify in case of emergency_____Phone Number_____

GENERAL CONSENT TO THERAPY

I give my consent to counseling, psychotherapy and/or diagnostic testing as prescribed by the therapist. I agree to be responsible for the payment of _____per session, (45-50 minutes) which is payable at the time of the session. I understand that I am responsible for payment, even though I may be reimbursed by my insurance company. I also understand that any appointment not kept, or not cancelled **24 hours** in advance, will be charged to me.

Therapist Initials_____

Signature of Client _____

If Minor, Signature of Responsible Parent _____

COUPLE INFORMATION

How long have you known your fiancé? _____ How long have you been dating? _____

What do you hope to gain from pre-marital counseling?

Are there any particular areas that you are looking forward to discussing?

Does your church require pre-marital counseling in order to be married in the church? _____

FAMILY INFORMATION

Parents: Father: Age_____ Occupation_____ Mother: Age_____ Occupation_____

Did you grow up with both parents in the home? Y ❑ N ❑ If your parents divorced, what age were you? _____

Did your parents remarry following divorce? Y ❑ N ❑ If yes, what age were you? _____

List names and ages of family members involved in therapy _____

_____

Please indicate any family history of the following by checking the appropriate box.

- ☐ Sexual abuse
- ☐ Substance Abuse
- ☐ Suicidality
- ☐ Chronic Mental Illness
- ☐ Eating Disorder
- ☐ Other:_____

TREATMENT/THERAPY HISTORY

Are you currently in therapy elsewhere? Y / N

Have you ever had any previous counseling or psychotherapy? Y❑ N❑ If YES, please list from most recent

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? _____

_____

If YES, method used: _____

Were you ever hospitalized for psychiatric reasons? Y❑ N❑ If Yes, when?_____ Length of hospital stay_____

MEDICAL INFORMATION

Current Weight_____ One Year Ago_____ Maximum_____ When_____

Do you exercise regularly? Y ❑ N ❑ How?_____

Do you sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

Primary Physician_____ City_____ Date of last physical_____

Please list all current medications:

MEDICATION	DOSE	REASON

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑

OTHER CONCERNS

	NEVER	SELDOM	SOMETIMES	OFTEN
Smoking	❑	❑	❑	❑
• Packs per week_____				
Alcohol Intake	❑	❑	❑	❑
• Frequency (per week):_____				
• How Much? _____				
• What do you drink? _____				
Marijuana	❑	❑	❑	❑
• Amount per week:_____				
Drugs (not medications)	❑	❑	❑	❑
• What? _____				
• Frequency:_____				

MEDICATION HISTORY

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑