



Marital Intake Form (Husband)

Demographics

Date: _____

Wife's Name: _____ Birthdate: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Phone (H) _____ (C) _____ (W) _____

Email: _____

Preferred Method of Contact (Circle One): Phone Call Phone Text Email

Religious Affiliation: _____

Employer: _____ Occupation: _____

Husband's Name: _____ Birthdate: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Phone (H) _____ (C) _____ (W) _____

Email: _____

Preferred Method of Contact (Circle One): Phone Call Phone Text Email

Religious Affiliation: _____

Employer: _____ Occupation: _____

Children: (Please indicate biological child, stepchild, or foster child)

<u>Name</u>	<u>Age</u>	<u>Biological</u> <u>Child</u>	<u>Step-</u> <u>Child</u>	<u>Foster</u> <u>Child</u>



Referred by: _____

Emergency Contact Information:

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

- I authorize release of information to this emergency contact individual(s) as needed for emergency purposes: yes ___ no ___

It is customary at NewSong practice to mail a letter of termination at the end of treatment. If the above is not at a safe or preferred mailing address for you to receive mail, please provide an alternate mailing address here:

Address: _____

City: _____ State: _____ Zip: _____



Husband - Relationship Information

1. What is the primary concern or issue that led you to decide to seek therapy?

2. Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? If yes, for either, how often and what substances are used?

3. Has anyone in the family ever struck, physically restrained, used violence against or injured another person within the family? Are there any current legal orders or restrictions? (If yes, please explain.)

4. Have either of you considered separating or divorce because of the current marital problems? If so, who and when?

5. Are child protective services Is Child Protective Services involved in your family? Yes No
If yes, please include your social worker's name and contact information:

6. List some strengths in your relationship.

7. List some weaknesses in your relationship.

8. How would you know that your time in therapy has been successful?



9. If therapy is helpful, how will your relationship be different?

Husband - Medical/Mental Health Information

- What, if any, medical health problems do you have? _____

- Are you on disability? Yes No Please describe: _____

- Are you currently taking medication for a mental or emotional condition? Yes No
Please list conditions and medications _____

- Have you ever been hospitalized for a mental or emotional condition? Yes No
If yes, please list where and when: _____

- Are your parents divorced? Yes No
If yes, how old were you? _____
- Briefly describe your childhood: (i.e. happy, chaotic, troubled) _____

- Are childhood events contributing to your current problems? Yes No
Please explain _____

Husband - Social Supports

- How satisfied are you with the support you receive from your family/friends? (Please circle) Very satisfied Satisfied Unsatisfied Very unsatisfied
- How many close friends do you have and how are they helpful? _____

- Have your current difficulties affected your family/friends/co-workers? Yes No



(Husband) Please check anything below that has happened to you in the past 3 years.

	Death of a spouse/partner
	Relationship Problems
	Changes in relationship status
	Death of another family member
	Family Problems (children/in-laws)
	Loss of Job
	Major illness or injury (yourself)
	Major illness or injury (family member)
	Financial problems
	Move to another city or state
	Legal problems
	Other

Please share any other information which might be helpful for your therapist to know.



Please Mark Those That Apply to YOU Personally (Husband)

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Headaches
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Shortness of breath dizziness, sweating
<input type="checkbox"/> Lost interest in activities previously enjoyed	<input type="checkbox"/> Recurrent undesirable thoughts
<input type="checkbox"/> Increased appetite	<input type="checkbox"/> Repetitive behaviors (handwashing) or mental acts (counting)
<input type="checkbox"/> Decreased appetite	<input type="checkbox"/> Nausea or abdominal stress
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fear of losing control
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Fear of dying
<input type="checkbox"/> Difficulty going to sleep	<input type="checkbox"/> Recurrent intrusive memories
<input type="checkbox"/> Difficulty staying asleep	<input type="checkbox"/> Flashbacks
<input type="checkbox"/> Excessive sleep	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Fatigue, loss of energy	<input type="checkbox"/> Efforts to avoid memories
<input type="checkbox"/> Feelings of worthlessness/inferiority	<input type="checkbox"/> Fear of social situations
<input type="checkbox"/> Inappropriate guilt	<input type="checkbox"/> Alcohol problems
<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Drug use problems
<input type="checkbox"/> Preoccupation with death	<input type="checkbox"/> Compulsive dieting
<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Vomiting, use of laxatives
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Overeating
<input type="checkbox"/> Excessive or uncontrollable worry	<input type="checkbox"/> Marital problems
<input type="checkbox"/> Self-Esteem issues	<input type="checkbox"/> Friend Relationship problems
<input type="checkbox"/> Careless forgetful, easily distracted, difficulty organizing, loses things	<input type="checkbox"/> Extended Family Relationship problems
<input type="checkbox"/> Restlessness	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Self-Control issues	<input type="checkbox"/> Financial/work problems/stress
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Career Choice issues
<input type="checkbox"/> Angry	<input type="checkbox"/> Fears about the future
<input type="checkbox"/> Irritable/easily upset, on edge	<input type="checkbox"/> Overwhelmed
<input type="checkbox"/> Decreased need for sleep	<input type="checkbox"/>
<input type="checkbox"/> Increased talking	<input type="checkbox"/>
<input type="checkbox"/> Racing thoughts	<input type="checkbox"/>
<input type="checkbox"/> Distractible	<input type="checkbox"/>
<input type="checkbox"/> Elevated mood	<input type="checkbox"/>
<input type="checkbox"/> Engaging in risky, pleasurable activities	<input type="checkbox"/>
<input type="checkbox"/> Mood swings	<input type="checkbox"/>
<input type="checkbox"/> Feeling of panic	<input type="checkbox"/>
<input type="checkbox"/> Pounding heart, chest pains, shaking	<input type="checkbox"/>