Marital Intake Form (Husband)

Demographics

Date: _____

Husband's Name: _____ Birthdate: _____

Race: American Indian/Alaska Native, African American/Black, Asian, White, Other:_____

Address: _____ City:_____

State: _____ Zip: _____ County: _____

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

Email: _____

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

Religious Affiliation: _____

Which best describes you: Employed Disabled Student

Employer: _____ Occupation: _____

Social Security Number: _____

Wife's Name: _____ DOB: _____

Address (if different from husband): _____

City: _____State: _____ Zip: _____

County: _____

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

Referred by: _____

Emergency Contact Information:

Name: _____

Relationship: _____ Phone:_____

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

Client's Name _____ Date of Birth _____

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

Name	Age	Biological Child	Step-Child	Foster Child

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.

_____

_____

_____

Client's Name _____ Date of Birth _____

Please Mark Those That Apply to YOU Personally (Husband)

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