MARRIAGE COUNSELING FORM

Name ______________________________ Phone (Home) ______________________________

Mobile _____________________________ Work ____________________________________

Date of Birth _________________________ SS#_____________________________________

Home Address ____

City ______________________________ State __________ Zip ________________

Occupation ____

Employer ____

Spouse's Name ______________________ Phone ____________________________________

Circle those numbers where I may call you: Home Mobile Work Spouse
Circle numbers where I might leave a message for you: Home Mobile Work Spouse
May I mail appropriately labeled correspondence to your home address? Yes No

Alternate Address (if applicable): ____

Referred by: ____

In case of emergency, contact:

Name: ____________________________________ Phone: ______________________________

What is the primary reason you are seeking a consultation? _____________________________

____

____

When did issues in the marriage first appear? ____

____

____

What, if anything, makes these issues worse? _______________________________________

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____

What, if anything, makes these issues better? ______________________________________

____

Have family members, friends or coworkers urged you to seek treatment? If so, why? ________

____

Please list other psychiatrists you have seen, previous diagnoses, and dates of treatment: _______

____

____

____

Please list all medications you are currently taking: ____________________________________

____

Please list all substances used or abused, now or in the past, and approximate dates: __________

____

____

Method of contraception: ____

Please list all drug allergies: ____

Please list all medical problems: ____

____

Please list all previous surgeries: ____

Please list all previous psychiatric hospitalizations: _____________________________________

____

____

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Please list all medical and psychiatric conditions present in family members (please include alcohol and drug abuse problems):

Parents: ____

____

Siblings: ____

____

Grandparents: ____

____

Aunts and Uncles: ____

____

Children: ____

____

What is your level of education? ______________________________

- I certify this information is true to the best of my knowledge. I will notify you of any change in my health status, or any of the above information.
- I understand 24 hour cancellation notice is required to avoid being charged for a scheduled appointment.
- I understand that, unless previous arrangements have been made, I am responsible for filing my own health insurance.

______________________________ ______________________________
(Signature) (Date)

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