Client Information Sheet-- for Marriage Counseling

Name: ______________________________________________ Age: ___________________

Home phone: _________________________ Cell phone: ________________________________

Address: _______________________________________ City:_________________ State: _______ Zip: _____________

Email address: __________________________________________________

Place of Employment: _______________________________________________ Job held: ________________________

How long have you been married? ___________________________

Have you been married before? (circle): Yes No. If yes, when and how long? __________________________

How did you hear about counseling at St. Mark's? _________________________________________________

Do you attend church? Yes/No If so, where? _____________________________________

Have you had any previous counseling? Yes/No
If so, when and where? ___________________________________________________________
Was it helpful? Yes/No Why or why not? ______________________________________________________________

Briefly describe what has caused you to seek marriage counseling.

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

What do you think your greatest strengths as a couple are?

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

What are you hoping to get out of marriage counseling? In other words, if counseling "works," how will you know?

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

In your own words, please tell me about your relationship with God. In other words, Who is God to you and how is God a source of support for you?

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

Please put a check beside any of the items below that describe problems you are now facing:

___Depression
___Anxiety
___Relationship problems
___Work pressures
___Physical problems/illness
___Spiritual Crisis
___Thoughts of Suicide
___Past abuse—physical, sexual, or emotional
___Current abuse--- physical, sexual, or emotional

___Substance abuse
___Anger
___Problems with children
___Pornography/ Sexual addiction
___Eating Disorder
___Guilt

Are you on any psychiatric medications? Yes/No If so, please list:

_______________________________________________________________________________

Is there anything else you would like for me to know before we begin?

_______________________________________________________________________________

_______________________________________________________________________________