Redemption KC Marriage Intake

*Each partner will fill out their own copy individually.

General Info:

Name:_____ **Date**: _____

Name of Partner:_____

Address: **City:** **Zip:**

Age: **Sex: Male____ Female____**

Phone: May we leave text messages for session reminders? Yes____ No____

Email: May we send emails with session reminders and/or resources? Yes____ No____

Occupation/Employer: **Avg. Hours/Week**:

Highest Degree (s) earned: **School:**

With whom do you currently live?

Relationship Status: (check all that apply)

□ Married
□ Separated
□ Divorced
□ Dating
□ Cohabitating
□ Living together
□ Living apart

Length of time in current relationship: _____

Have you been married before? _____ If so, when and for how long? _____

Any other information about prior romantic relationships that would be helpful for us to know?

Any children? ____Yes___No If so, list their names and ages. If you and/or your partner have children from a prior relationship(s) please specify below.

PERSONAL HISTORY

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? □ Yes □ No

If so, for how long and what reason:

_____

Have you had any mental health services in the past? □ Yes □ No

If so, for how long and for what reason?

II. Spiritual/Church Information:

What church do you attend and for how long have you attended?

Have you received Christ as your savior, and, if so, how do you know?

Any recent changes in your spiritual life?

III. Health/Medical

Are you on any medication? ____Yes ____No

If so, describe the dosage, frequency, what the medication is prescribed for, and how long you've been taking it.

Do you consume alcohol regularly? □ Yes □ No

In one month, how many times do you have 4 or more drinks in a 24-hour period?_____

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

Have you felt depressed recently? □ Yes □ No If yes, for how long?_____ List your symptoms of depression.

_____

Have you had suicidal thoughts in your past? □ Yes □ No If yes, how long ago?_____

How often? □ Frequently □ Sometimes □ Rarely

Do you engage in any form of self-harm? □ Yes □ No If yes, please list:

Quick Check: (Check all that apply)

□ Extreme depressed mood
□ Mood swings
□ Rapid speech
□ Extreme anxiety
□ Panic attacks
□ Phobias
□ Disturbed sleep
□ Hallucinations
□ Memory lapse
□ Alcohol/substance abuse
□ Body complaints
□ Eating disorder

□ Repetitive thoughts
□ Anxiety
□ Time loss
□ Repetitive behaviors
□ Homicidal thoughts
□ Suicide attempts
□ Trouble planning
□ Relationship trouble
□ Aggression
□ Anger
□ Addictive Behavior
□ Anhedonia (no pleasure in life activities)
□ Bereavement
□ Dissociation

□ Hopelessness
□ Helplessness
□ PTSD
□ Pornography Use
□ Sexual Addiction
□ Tearful
□ Worry
□ Sexual Concerns
□ Bingeing
□ Purging
□ Restricting Intake
□ Depression
□ Impulsiveness
□ Compulsion

OTHER? Specify below:

IV. Family Information:

1. Are your parents married or divorced/separated and/or remarried?

2. How many siblings do you have and where do you fall in the birth order?

3. How would you describe your family's financial situation growing up?

4. Did you have any significant traumas as a child? Please describe.

5. Please describe any family history (the family you grew up in) which might be pertinent to the concerns you bring to counseling (your relationship with your parents, their relationships with each other, significant losses or events).

MARITAL HISTORY

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern □
No concern
□ Little concern
□ Moderate concern
□ Serious concern
□ Very serious concern

Frequency □
No occurrence
□ Occurs rarely
□ Occurs sometimes
□ Occurs frequently
□ Occurs nearly always

What do you hope to accomplish through counseling?

_____

_____

_____

What have you already done to deal with the difficulties in your relationship?

_____

_____

_____

What are your biggest strengths as a couple?

_____

_____

_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

_____

_____

_____

Have you received prior couples counseling related to any of the above problems? □ Yes □ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

_____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in *individual* counseling before? □ Yes □ No
If so, give a brief summary of concerns that you addressed.

_____

_____

_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? Yes □ No □
If yes for either, who, how often and what drugs or alcohol?

_____

_____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

Yes □ No □ If yes for either, who, how often and what happened.

_____

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

Yes □ No □ If yes, who? ___Me ___Partner ___Both of us

Have either you or your partner consulted with a lawyer about divorce?

Yes □ No □ If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? Yes □ No □

If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? _____times

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

Rank the top three concerns that you have in your relationship with your partner (1 being the most problematic):

1. _____

2. _____

3. _____

Rank the spiritual health of your relationship with your partner. (Circle one)

1 2 3 4 5 6 7 8 9 10
(Unhealthy) (Healthy)

Do you and your partner attend church together? Yes □ No □

If yes, where do you attend and how often?

How often do you and your partner read scripture, pray, or talk about spiritual things? If able, give an example of what you might read or pray about.

Do you ever feel judged or condemned by the way you partner uses scripture, prayer, or spiritual conversation? If so, describe.

_____

_____

_____

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note *pivotal/significant events* in your relationship (e.g., one of you moved out, one of you cheated).

Complete satisfaction

No satisfaction

Relationship over time

When you met/began dating ***Current***

Any additional information you would like to add?

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.