

# Thrive Counseling Group

## Premarital Intake Form

This information will remain confidential.

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_  
Age: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ Can we leave a message? \_\_\_ Email: \_\_\_\_\_  
Employed at: \_\_\_\_\_  
**Emergency Contact** : Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone #(s) \_\_\_\_\_

### Relationship status:

Current Relationship status: \_\_\_ Seriously Dating \_\_\_ Engaged \_\_\_ Separated  
How long have you been together: \_\_\_\_\_  
If engaged, how long have you been engaged? \_\_\_\_\_  
How long have you known your fiancé? \_\_\_\_\_  
How many times have you been engaged? \_\_\_\_\_  
Have you ever been married before? \_\_\_\_\_

**Current Household Family:** Do you have children? Yes No If yes provide information below:

Name	Age	Lives at	(Circle One)
			Biological / adopted / step-child
			Biological / adopted / step-child
			Biological / adopted / step-child

### Family-of-Origin

Mothers Age: \_\_\_\_\_ If deceased, how old were you when she died? \_\_\_\_\_  
Father's Age: \_\_\_\_\_ If deceased, how old were you when he died? \_\_\_\_\_  
Number of Brothers: \_\_\_\_\_ Their ages: \_\_\_\_\_  
Number of sisters: \_\_\_\_\_ Their ages: \_\_\_\_\_

Briefly describe your relationship with your father:

\_\_\_\_\_  
\_\_\_\_\_

Briefly describe your relationship with your mother:

\_\_\_\_\_  
\_\_\_\_\_

List family members with mental health past:

\_\_\_\_\_

### Educational Background:

GED HS Diploma Associate's/Technical Degree Bachelor's Degree Post-Graduate Degree Other  
If degree applies please specify major: \_\_\_\_\_

**Religious / Spiritual Background:**

Were you affiliated with any church / religion growing up? Yes \_\_\_ No \_\_\_ What Church or Religion? \_\_\_\_\_

Are you currently affiliated or attending a church/religion now? Yes \_\_\_ No \_\_\_ What Church or Religion? \_\_\_\_\_

Describe your religious upbringing? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe your current relationship with God: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What differences / similarities have you discussed concerning religious / spirituality? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical history:**

Do you have any significant health/medical issues? Yes \_\_\_ No \_\_\_ If yes what is/are the health issue(s) and are you limited in any way?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had a trauma to head, unconsciousness, or seizures? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

**Counseling History:** Have you attended counseling previously? Yes \_\_\_ No \_\_\_

When (Specify Dates): \_\_\_\_\_ Where and with whom: \_\_\_\_\_ Presenting issues at that time: \_\_\_\_\_ Diagnosis given: \_\_\_\_\_


Are you currently in therapy or counseling with anyone? Yes \_\_\_ No \_\_\_

Whom \_\_\_\_\_ Where \_\_\_\_\_

How long \_\_\_\_\_ Reason \_\_\_\_\_

Describe the experience \_\_\_\_\_

**Have you ever been hospitalized for any mental health reasons?** Yes \_\_\_ No \_\_\_

When \_\_\_\_\_ Where: \_\_\_\_\_ Reason: \_\_\_\_\_ Presenting problem / Diagnosis \_\_\_\_\_


**Psychotropic medications:** Are you currently taking any psychotropic medications? Yes \_\_\_ No \_\_\_

(Specify current & past meds)

Medication      Condition      /      Dosage      Dates of usage /      Side effects      Physician


**Alcohol/drug usage:**

Do you currently use alcohol or drugs? Yes \_\_\_ No \_\_\_

Describe the use of drugs and alcohol (type, amount, frequency): \_\_\_\_\_

When did you start using drugs or alcohol? \_\_\_\_\_

What has your past use of alcohol been like? \_\_\_\_\_

**Suicide risk:** Have you ever attempted suicide? Yes \_\_\_ No \_\_\_  
If yes, when? \_\_\_\_\_ How many times? \_\_\_\_\_  
Have you recently had thoughts of suicide? Yes \_\_\_ No \_\_\_  
How or what did you plan to do? \_\_\_\_\_  
What were the circumstances at the time? \_\_\_\_\_  
Has anyone close to you ever attempted or committed suicide? Yes \_\_\_ No \_\_\_  
If yes, who, how, and when? \_\_\_\_\_

**Abuse history:** Please circle if you have either been physically, emotionally, or sexually abused?  
If yes, briefly explain (who, what and when): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Support Systems:**  
Do you have people that you can turn to for support? Yes \_\_\_ No \_\_\_  
If yes, who? \_\_\_\_\_ Relationship to you: \_\_\_\_\_

**Presenting Issues:**  
Briefly explain what concern(s) that you would like to address during premarital counseling: \_\_\_\_\_  
\_\_\_\_\_

What do you hope to achieve or accomplish through premarital counseling? \_\_\_\_\_  
\_\_\_\_\_

Please describe what you believe your fiancé's specific goals for counseling: \_\_\_\_\_  
\_\_\_\_\_

What concerns do you hope to resolve by the time you get married?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please rate the following topics from 1-6 (with 1 being most needed) indicating in what area you feel you need the most assistance as a couple:

\_\_\_ Finances    \_\_\_ Distribution of Household Responsibilities    \_\_\_ Children/Parenting    \_\_\_ Intimacy/Sex  
\_\_\_ Role of Friends/Extended Family    \_\_\_ The role of Spirituality/Religion in your lives

What would you say that your greatest strengths are as a couple?  
\_\_\_\_\_  
\_\_\_\_\_

**Referral Information**

How did you hear about us?  
\_\_\_ Referred by therapist \_\_\_\_\_  
\_\_\_ Referred by a friend \_\_\_\_\_  
\_\_\_ Referred by a minister/pastor \_\_\_\_\_  
\_\_\_ Web Site \_\_\_\_\_  
Other \_\_\_\_\_

May we have your permission to thank the person who referred you to us? Yes \_\_\_ No \_\_\_