



Loganville Community Ministry Village

Marriage Counseling Intake Form

Husband's Name _____ Age _____

Wife's Name _____ Age _____

Address _____ City, State & Zip _____

Home Phone _____ Cell Phone _____

Email _____

Husband's Employer _____ Occupation _____

Work Phone _____

Wife's Employer _____ Occupation _____

Work Phone _____

*Where do you prefer to be contacted? _____

Do you have children? _____ If so, please list below.

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Emergency Contact _____

Phone Number _____ Relationship _____

Who referred you to our office? _____

Please briefly describe your reason for seeking counseling at this time

Client's Signature _____ Date _____

Client History

Name of current physician _____ Phone Number _____

Are you currently taking any prescription medication? _____
(If yes please list below)

Is there a history of drug abuse _____ If so, which drugs _____
Do you drink alcohol? _____ How often? _____

Have you had any previous therapy/ counseling? _____

Name of therapist _____

Has either of you ever been hospitalized for mental illness? _____
If yes, when _____ where _____

One a scale 1-100, with 1 being horrible and 100 being wonderful, where would you rate your current state? _____

Does spirituality play an important role in your life? _____

Do you attend church regularly? _____ If so where _____

Do you mind if your counselor prays for/with you during your sessions? _____

Please list any additional information that you feel may be important

