Marriage Connect
PO Box 25786
Colorado Springs, CO 80936
Phone 720.209.6659

INFORMATION SHEET

Full Name ____

Address ____________________________ City ______________ Zip ________

Phone: Cell:______________ Home/work ________________ E-Mail ____________________

Age _______ D.O.B. ________________________

Religious preference ___________________________ Occupation ________________________

Briefly describe your reasons for seeking help: ____________________________________

____

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____

____

Have you had counseling before?________ Was it helpful? ____________________________

List any health problems for which you are currently receiving treatment_________________

____

____

Medication(s) ____

____

Marital History: Never married ________

1st marriage: Date(s) ___________ Spouse ___________ Children ____________________

2nd marriage: Date(s) ___________ Spouse ___________ Children ____________________

3rd marriage: Date(s) ___________ Spouse ___________ Children ____________________

Who has custody of your minor children? ____________________________________

Have you ever considered suicide? _________ Attempted? _________

(Over)

Check any of the following that are currently causing you difficulty:

❑ Anger
❑ My Past
❑ Anxiety
❑ Nightmares
❑ Phobia
❑ Assertiveness
❑ Addiction
❑ Divorce
❑ Self-control
❑ Cutting
❑ Health
❑ Dating
❑ Shame

❑ Panic Attacks
❑ Grief
❑ Suicidal thoughts
❑ Parents
❑ Hearing Voices
❑ Depression
❑ Obsessiveness
❑ Cutting
❑ Career choices
❑ Self-concept
❑ Marriage
❑ Concentration
❑ Work

❑ Energy
❑ Sleep Trouble
❑ Guilt
❑ Stepfamily
❑ Legal Issues
❑ Parenting
❑ Food
❑ Religion
❑ Finances
❑ Headaches
❑ Abuse
❑ Violence
❑ Sadness

❑ In-laws
❑ Hopelessness
❑ School
❑ Peers
❑ Teachers
❑ Friendships
❑ Siblings
❑ Other:
____
____
____
____

Signature ____ Date ____________________
(Client/Guardian)