

PAMELA KING THERAPY

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210-885-5009

****CONFIDENTIAL INFORMATION****

PREMARITAL INTAKE FORM

Date: _____

How did you hear of me: _____

Name: _____
Last First Birth date Age

Ethnicity (circle one): Caucasian Hispanic African American Middle Eastern Other: _____

Address: _____
Street City State Zip

Phone: (____) _____ (____) _____
Home Mobile

E-mail address: _____

Occupation: _____ Education: _____

Employer: _____ How Long: _____

Years of school
Special training(s): _____

Military history: _____ Combat: _____

Marital status (circle one): Single Married Divorced Separated Widowed

Fiancé: _____ (____) _____
Name Phone

Years Together: _____

Fiancé's Date of Birth: _____ Age _____

Fiancé Occupation: _____ Education: _____

Fiancé's special training(s): _____

Fiancé military history: _____ Combat: _____

Previous Marriages/Serious Relationships

Spouse/SO's Name	# of children from Relationship	Length of relationship	Reason for divorce/end
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Children:

Name	M/F	Age	Does the child live with you?	Is the child a result of current relationship?

Who else, if anyone, shares your residence.

Name	Relationship	Age

18. Your Family of Origin (your parents and your siblings):

Name	Their Relationship to you	Age (if Living)	Additional information (Age and Year of Death, Married, City of Residence, Quality of Relationship)

Spiritual Faith or Participation: _____

Would you like your spiritual beliefs to be a part of the counseling? Yes No

General physical and mental health:

Illnesses/disabilities:

Medications – indicate what condition they are treating and how long you have been taking each:

Previous counseling (Circle one): Yes No

If yes, give reason(s) for previous counseling/therapy: _____

**Therapist
Name** _____

**Dates of
Counseling** _____

Organization _____

Please indicate if you are experiencing any of the following:

- ☐ Alcohol/Substance abuse by self ☐ Family Problems ☐ Eating Disorders
☐ Alcohol/Substance Abuse by others ☐ Poor appetite
☐ Hopelessness, Helplessness ☐ Fatigue
☐ Sexual Addiction ☐ Guilt, Worthlessness ☐ Muscle Twitching
☐ Physical Abuse ☐ Restlessness ☐ Chest Pain
☐ Emotional Abuse ☐ Crying Spells ☐ Shortness of Breath
☐ Sexual Abuse ☐ Sudden weight gain/loss ☐ Excessive Sweating
☐ Anxiety ☐ Insomnia ☐ Muscle Aches
☐ Thoughts of Suicide ☐ Excessive Sleeping ☐ Panic Attacks
☐ Grief ☐ Decreased Concentration ☐ Dizziness/Faintness
☐ Illness ☐ Loss of interests ☐ Digestive Problems
☐ Spiritual Problems ☐ Racing Thoughts ☐ Rapid/Pounding pulse
☐ Adjustments to life changes ☐ Uncontrollable thoughts
☐ Uncontrollable behaviors ☐ Cold Hands ☐ Numbness in fingers
☐ Criminal Problems ☐ Anger ☐ Excessive Sweating
☐ Financial Problems ☐ Irritability ☐ Dry Mouth
☐ Abortion ☐ Miscarriages ☐ Mood Changes
☐ Anti-Social Behavior/Withdrawing ☐ Fear of: _____ ☐ Other: _____

Goals of Counseling

Please list three goals you want to accomplish during premarital counseling:

1. _____
2. _____
3. _____

Topics of Discussion

Please list three topics you want to make sure to discuss during premarital counseling:

1. _____
2. _____
3. _____

Spiritual Background

Discuss your spiritual background, current spiritual practices, and importance you place on spiritual matters.

Family Background

What is important for me to know about your family (current or history)?

[illegible]

Date, Place and Time of Wedding Ceremony:

Information Sharing

Have you shared, or do you plan to share, the information in this intake with your fiancée?

☐ Yes ☐ No

If you would like to privately discuss anything in this intake with me, please indicate the topics here:

Signature

Date _____