

**Cord of Three Counseling Services
Married Couple Intake Form**

Husband Cell Phone _____	Wife Cell Phone _____
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BACKGROUND INFORMATION

Husband Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Employer: _____ Occupation: _____

Email: _____ Home Phone: _____

Wife Name: _____ SSN: _____ DOB: _____

Address (if different) _____ City: _____ GA, Zip: _____

Employer: _____ Occupation: _____

Email: _____

Emergency Contact Person: _____ Emer. Contact #: _____

Husband Age: _____ Wife Age: _____ Ethnicity: _____

Church of Attendance: _____ Active Member: Yes No

Marital Status:
Married
Separated
Divorced
Yrs. Married _____

Highest Education Completed:
H W
High School
College
Graduate School
Professional School
Other _____

If you are or ever have been divorced or are separated, please explain the situation.

Describe any physical problems you have that require medication or physical care:

Medication(s) currently using:

Are either or you currently or have you ever received counseling? Yes No

If yes, when and with whom?

please complete both sides

Place a check by any of the symptoms in the chart below which describes the reasons why you/your family are currently seeking counseling services:

<input type="checkbox"/> Anger/Temper	<input type="checkbox"/> Problems with Social Relationships	<input type="checkbox"/> Unhappy most of the time
<input type="checkbox"/> Depression	<input type="checkbox"/> Problems Sleeping	<input type="checkbox"/> Use of Alcohol
<input type="checkbox"/> Marital Problems	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Use of Drugs
<input type="checkbox"/> Obsessiveness	<input type="checkbox"/> Sexual Concerns	<input type="checkbox"/> Work
<input type="checkbox"/> Stress	<input type="checkbox"/> Religious/Spiritual Concerns	<input type="checkbox"/> Worry
<input type="checkbox"/> Family Problems	<input type="checkbox"/> Talk of Suicide	<input type="checkbox"/> Self-Esteem
<input type="checkbox"/> Fearfulness	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Poor Appetite
<input type="checkbox"/> Physical Problems		<input type="checkbox"/> Overeating
<input type="checkbox"/> Compulsions		<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Financial Problems		

Other Problems (Please explain):

In your own words, please briefly describe the main problem(s) which prompted you to seek counseling with Cord of Three at this time:

Is there anything else which you believe might be important for your counselor to know at this time?

I learned about Cord of Three Counseling Services from:

Name: _____
 Address: _____
 City/State/Zip: _____
 Phone: _____

Please share your goals and values for relationship?

What do you hope is changed as a result of coming to counseling?

What is your definition of a Christian? How does one become a Christian?

I understand that I am financially responsible for payment of services received by me or my dependent(s). I authorize the release of clinical or medical information to my insurance company, primary care physician and referral source or agency when needed for insurance coverage and/or payment. I understand that insurance claims will be electronically filed to my insurance carrier on my behalf. I am responsible for payment(s) not received from the insurance company within 90 days of treatment and will make payment to Cord of Three Counseling Services. I assign insurance benefits payable to me to Cord of Three Counseling Services Inc.

 Husband's Signature

 Date

 Wife's Signature

 Date

please complete both sides