

From the Office of  
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## Pre-Marital Information Form

Client Name \_\_\_\_\_ Date of Visit \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Permission to call? \_\_\_\_\_ Leave Message? \_\_\_\_\_

Work Telephone \_\_\_\_\_ Permission to call? \_\_\_\_\_ Leave Message? \_\_\_\_\_

Cell Telephone \_\_\_\_\_ Permission to call? \_\_\_\_\_ Text? \_\_\_\_\_ Leave Message? \_\_\_\_\_

Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Referred by \_\_\_\_\_

Insurance # \_\_\_\_\_ Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employed by \_\_\_\_\_ Position \_\_\_\_\_

Name of Partner \_\_\_\_\_

Employed by \_\_\_\_\_ Position \_\_\_\_\_

Name and Ages of Children and others in your household

\_\_\_\_\_

\_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Current Medications and Medical Concerns

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous Counseling History: (therapist, dates, problem, outcome)

\_\_\_\_\_

\_\_\_\_\_

What do you value most about your partner?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What would you like to happen as a result of coming here?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_