

TODAY'S DATE: _____

YOUR INFORMATION

Name: _____
Age: _____ Address: _____ State: _____ Zip: _____
City: _____
Home Phone: _____ Business Phone: _____
Mobile #: _____ Email Address: _____
Profession: _____
Number Years Married to Current Spouse: _____
Children's Names and Ages: _____
Previous Marriage(s) & Length of Marriage(s): _____

SPOUSE'S INFORMATION

Spouse's Name: _____
Spouse's Address: _____ State: _____ Zip: _____
City: _____
Spouse's Age: _____
Spouse's Previous Marriage(s) & Number Years Previously Married: _____
Spouse's Health: _____
Spouse's Profession: _____

YOUR FAMILY OF ORIGIN

Mother's Name: _____ Mother's Profession: _____
Father's Name _____ Father's Profession: _____
Mother's Age: _____ Mother's Location: _____
Father's Age: _____ Father's Location: _____
Mother's Health: _____
Father's Health: _____

Write 3 positive adjectives to describe your Mother:
(1) _____
(2) _____
(3) _____

Write 3 negative adjectives to describe your mother:
(1) _____
(2) _____
(3) _____

Write 3 adjectives to describe your Father:
(1) _____
(2) _____
(3) _____

Write 3 negative adjectives to describe your Father:
(1) _____
(2) _____
(3) _____

CURRENT PROBLEM/ISSUES - Please provide description of current problems and issues to be addressed:

HEALTH CHECKLIST - Check all that apply to each family member and yourself

| | You | Spouse | Children | Briefly Explain |
|-------------------|--------------------------|--------------------------|--------------------------|------------------------|
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Drinking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Substance Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Anger | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Workaholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Food Addiction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Spending/Gambling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sex Addiction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Physical Health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

ADDITIONAL INFORMATION

I would like each of you attending the session to send a one-page summary to me giving background information and your desired outcomes for the session. Please limit your response to a single page.
