****

**Seven Trees Counseling**

**Gil R. Stuart, LMHC & Brenda Stuart, CTC**

**Marriage Restoration Intensive**

**ADULT INFORMATION QUESTIONNAIRE**

Today’s Date: *Return form by email or just bring with you*

Name First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_ Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male Female

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Apt # City State Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave a message? Yes No

Age\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_ Church \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member? Yes / No

Marital Status (Check one) Single Married Remarried Separated Divorced Widowed

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone (\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_ Can we call you at work? Yes No

Email addresses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Level of Education Grade School High School Technical Degree Bachelor’s Degree Master’s Degree Advanced Degree

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex Male Female

Age\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_Church \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member? Yes No

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Phone (\_ )\_\_\_\_\_\_\_\_\_\_\_

Highest Level of Education Grade School High School Technical Degree Bachelor’s Degree Master’s Degree Advanced Degree

Gross Annual Household Income (required): Husband \_\_\_\_\_\_\_\_\_\_\_\_\_Wife \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: Friend\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Minister/Church Restored & Remarried Social Media Online

Who referred you? ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever consulted a professional counselor or psychiatrist? Yes No Hospitalized? Yes No

Counselor Name City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problem Addressed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor Name City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problem Addressed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently taking any medication? Yes No

If yes, please list each and dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital History/Parent/Guardian Information**

**Number of marriages including the current marriage:** Husband \_\_\_\_\_Wife\_\_\_\_\_\_

List Husband’s Spouse(s) name Dates Married (From & To) List Wife’s Spouse(s) name Dates Married (From & To)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children from Previous and Current Relationships**

Child’s Name Age Biological Parents names Child’s Name Age Biological Parents names

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the those currently living in your home (list part-time children as well):

Name Age \_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Age \_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Age \_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Age \_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Age \_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Age \_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe your reason for seeking therapy?

How will you know when therapy has been successful?

Please provide any additional information, which you feel pertinent for therapy?

**MENTAL HEALTH SERVICES INFORMED CONSENT**

When you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications with a therapist in treatment are confidential and may not be disclosed without your permission, except as required by law. For example, therapists still must report suspected child abuse and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. You understand that information shared in sessions may be subject to disclosure, at the discretion of the therapist, among all family members who attend.

**FINANCIAL AGREEMENT**

I understand that I am required to make payment at the time services are rendered (preferably by cash or check). I am financially responsible for all charges (whether or not I can be reimbursed by insurance). I further agree that a photocopy of this agreement shall be valid as the original.

You have the right to be informed of the cost of services rendered to you. Payment is due in full at the time services are rendered unless previous arrangements have been made. Please notify us within 24 hours of your appointment should you need to cancel.

**AUTHORIZATION FOR CLINICAL SERVICES**

I, the undersigned, request therapy from Gil R. Stuart, LMHC and hereby authorize him to administer such assessment and treatment as deemed necessary. I also certify that no guarantee or assurance has been made as to the results or outcomes that may be obtained. Assessment/treatment includes the risk of emotional discomfort related to issues discussed during the counseling process. I understand that I am free to discontinue therapy at any time. I am aware that Gil cannot handle life or death emergencies and is not available 24 hours a day. After hours, I am requested to call my primary care physician or 911 for an emergency.

**SIGNATURE**

I certify that the information that I have provided on this form is true and accurate. I have read and understand the above rights, authorizations, and responsibilities and have signed below to indicate my agreement with these terms. I have received a copy of Gil’s Professional Disclosure Statement and Client Consent Agreement and have signed below to indicate my agreement with its terms.

Client #1 Signature Date

Therapist Date