Couples Life Skills
Intake Face Sheet

Please Print Clearly:
Your name is automatically added to our mailing list for future events. ❑ Please do not add my name to mailing list.

Check one box: ❑ First-time to SOTM ❑ Returning - last time with SOTM_____

Today's Date _____ Wedding Date: _____

Groom's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____Work Phone: (_____)_____

E-Mail: _____ Cellular: (_____)_____

Date of Birth _____ Place of Birth __ _____

Occupation: _____

Is this your first marriage? (_____) Yes (_____) No If No, how many previous marriages: _____

Any Children? (_____) Yes (_____) No If Yes, how many children?: _____

Bride's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____Work Phone: (_____)_____

E-Mail: _____ Cellular: (_____)_____

Date of Birth _____ Place of Birth __ _____

Occupation: _____

Is this your first marriage? (_____) Yes (_____) No If No, how many previous marriages: _____

Any Children? (_____) Yes (_____) No If Yes , how many children?: _____

How did you learn of SOTM Life Skills? _____

In the event of an emergency, please contact _____

Relationship _____Phone ( ) _____