**Ann E. Hawkins, MFT
Licensed Marriage & Family Therapist # 77747**

Confidential Information Form

*Welcome to my practice. Please take a few minutes to fill out this form as completely as possible. It will help me in our work together. Information is confidential, as outlined in the Office Policy form. If you do not wish to answer any question, please simply write: “Do not care to answer.” Please print or write clearly and bring it to your first session. Thank you.*

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_

Address:

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

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Messages*: q Okay machine q Okay other resident q No message

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Messages*: q Okay machine q No message

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Messages*: q Okay machine q No message

Emergency Contact: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we send material/information to your home? q Yes q No

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

Highest Grade/Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Names of Individuals in the Primary Household** (Please check those who are attending counseling.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 3 | **first & last name** | **relation** | **birth date** | **school/grade** | **ethnicity** |
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**Medical/Health Information**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health professionals treating you:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications you are currently taking:**

|  |  |  |  |
| --- | --- | --- | --- |
| **name of medication** | **dosage** | **prescribed by** | **for what? how long?** |
|  |  |  |  |
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Please describe any health conditions that you are currently being treated for, and/or any significant medical issues in the past:

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| --- |
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|  |

Have you been in therapy before? q Yes q No If so, please describe:

|  |  |  |  |
| --- | --- | --- | --- |
| **therapist** | **type of issues** | **how long?** | **comments** |
|  |  |  |  |
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Describe past or present drug or alcohol use/abuse:

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**Relationship History**

**Past & Present Marriages/Partnerships** (years together, names, & statement about the nature of the relationship, i.e. friendly, distant, physically/emotionally abusive, loving, hostile):

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|  |

**Children – Stepchildren – Grandchildren**

|  |  |  |  |
| --- | --- | --- | --- |
| **name** | **age** | **relationship** | **comments** |
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**Family of Origin** (name/age or year of death, causes of death, statement about the relationship):

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| --- |
| father: |
|  |
|  |
| mother: |
|  |
|  |
| step-parents/caregivers |
|  |
|  |
| Siblings |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |