

Hannah Hawkins-Esther LCSW

Pine River Psychotherapy
Voicemail: 770-595-4510
1145 Sheridan Rd
Atlanta, Ga. 30324

New Client Information

Date: ____ / ____ / ____

NAMES

Phone: Home _____ Work _____

Cell: **Partner 1** _____ **Partner 2** _____

Email: _____

Email: _____

Address _____

(City)

(State)

(Zip code)

Partner 1: Age: _____ Date of birth: _____

If employed, occupation: _____ Employer: _____

Length of time at current job: _____

Highest Grade/Degree Completed :

Partner 2: Age: _____ Date of birth: _____

If employed, occupation: _____ Employer: _____

Length of time at current job: _____

Highest Grade/Degree Completed:

Any Religious or Spiritual Practices

How did you find me?

Do you give permission to Hannah Hawkins-Esther to contact the person who referred you?
Y / N

Relationship status (please circle all that apply):

Single Engaged Married Partnered Separated Divorced Widowed Other _____

If married/partnered/engaged how long? _____

Past long term relationships/marriages?

Partner 1 _____

Partner 2 _____

Others living in home (please include relationship & age):

Local Physician : _____

Current physical problems, symptoms or concerns by either partner or both?

Any history of physical problems/hospitalizations?

Current prescription medications (name & dosage):

Prescribed by: (name and Phone) _____

Currently in individual counseling/psychotherapy? Partner 1 Yes _____ No _____
Partner 2 Yes _____ No _____

If yes, name of therapist: _____

Previous couples counseling/psychotherapy? Yes _____ No _____

How long? _____ When? _____

Previous psychiatric hospitalization: Yes _____ No _____

If yes, where?

_____ When? _____

Length of stay?

Partner 1 Parental Status:

Living together _____ Father Deceased _____

Separated/divorced _____ Mother deceased _____

If living, father's age _____ Mother's age _____

If not, year of death _____ Year of death _____

Partner 2 Parental Status:

Living together _____ Father Deceased _____

Separated/divorced _____ Mother deceased _____

If living, father's age _____ Mother's age _____

If not, year of death _____ Year of death _____

Name, & phone # of someone in case of emergency:

Describe your reason for seeking help:

Please explain prior efforts to handle the problem:

Briefly describe what you hope to get out of psychotherapy:

Partner 1: Please circle any of the following problems that pertain to you:

Relationships	Suicidal Thoughts	Family Problems	Negative thoughts	Grief
Nervousness	Depression	Alcohol /Drug Use	Temper	Shyness
Self-Control	Appetite	Voices/Visions	Nightmares	Marriage
Sexual Problems	Anger	Finances	Parenting Concerns	
Stomach Trouble	Unhappiness	Career Choices	Stress	Sleep
Relaxation	Headaches	Bowel Troubles	Legal Matters	Work
Concentration	Inferiority	Energy	Insomnia	Memory
Decisions	Loneliness	Unusual Sounds	My thoughts	Ambition
School	Spiritual Issues	Health Problems	Tiredness	Binging
Purging Worries	Restricting	Divorce	Fears	Excessive

Please add any more information or list any other problems you feel important

Partner 2: Please circle any of the following problems that pertain to you:

Relationships	Suicidal Thoughts	Family Problems	Negative thoughts	Grief
Nervousness	Depression	Alcohol /Drug Use	Temper	Shyness
Self-Control	Appetite	Voices/Visions	Nightmares	Marriage
Sexual Problems	Anger	Finances	Parenting Concerns	
Stomach Trouble	Unhappiness	Career Choices	Stress	Sleep
Relaxation	Headaches	Bowel Troubles	Legal Matters	Work
Concentration	Inferiority	Energy	Insomnia	Memory
Decisions	Loneliness	Unusual Sounds	My thoughts	Ambition
School	Spiritual Issues	Health Problems	Tiredness	Binging
Purging Worries	Restricting	Divorce	Fears	Excessive

Please add any more information or list any other problems you feel important

We understand that my fee for a 45 minute session is \$225.00 payable at the time services are rendered. I further understand that other than an emergency, failure on my part to give at least 24 hours notice of a cancellation will result in my being billed for this session.,

Signature _____

Signature _____

Date _____

Therapist signature _____

Date _____

PARTNER REVIEW: Each partner consider and answer as it feels appropriate

1. What do I want to learn or understand?

2. What do I want to stop doing?

3. What do I want to start doing differently to build a more loving relationship?

4. What is most urgent for me?

5. What is distressing to your partner about you and about the way you interact?

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3. What do I want to start doing differently to build a more loving relationship?

4. What is most urgent for me?

5. What is distressing to your partner about you and about the way you interact?