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 Restricting Divorce Fears Excessive Worries

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

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School Spiritual Issues Health Problems Tiredness Binging

Purging Restricting Divorce Fears Excessive Worries

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

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We understand that my fee for a 45 minute session is $245.00 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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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?