

Midtown Family Therapy Group
Confidential Information Form

Date of Intake _____

Name of Client:

Last Name: _____ First Name: _____ M.I.: _____ DOB: _____

Address: _____ City/State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____ Occupation: _____

Email: _____ Cell Phone: _____ Pager: _____

Highest Education Completed: _____ Religious Affiliation: _____

Current Marital Status (circle one) Never Married Married (date _____) Separated Divorced Widowed

Spouse or Next of Kin:

Last Name: _____ First Name: _____ M.I.: _____ DOB: _____

Address: _____ City/State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____ Occupation: _____

Email: _____ Cell Phone: _____ Pager: _____

Highest Education Completed: _____ Religious Affiliation: _____

Current Marital Status (circle one) Never Married Married (date _____) Separated Divorced Widowed

Children: (List all children by all marriages whether living at home or not)

Name	Sex	Age	Birth Date	Education	Living at home?

Anyone else living in the home? Y N Name: _____ Relation _____

In what way may the counselor assist you? _____

Midtown Family Therapy

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www.midtownfamilytherapy.com

List any recent stressful events or changes that have occurred in the last year (death of friends or relatives, marriages, births, divorces, changes in work, school residence or church, etc.)

Have you been in counseling previously? Y N When? _____ How Long? _____

Who may I thank for referring you to me? _____

Would it be helpful to contact your doctor or pastor, etc.? _____

If yes, please provide:

Name	Phone Number	Specify if Doctor, Pastor, or other
_____	_____	_____

Medical History

Family Member	List any recent illnesses, tests, hospitalizations	List all medications	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who may I contact in case of emergency? _____ Phone _____

I have received and read:

_____ The Description of Counseling, State of Confidentiality
Initials

_____ Notice of Privacy Practices and Fee Policy Statements
Initials

I consent to and authorize Midtown Family Therapy Group to provide counseling services.

Client Signature

Date

Client Signature

Date

Parent/Guardian/Responsible Party Signature

Date