Sharon Thompson, MA, LMFT
Marriage and Family Therapist

CONFIDENTIAL INFORMATION FORM

Date: ____________________

Name: ____ Age: ___________

Sex: male ____ female _____ Date of Birth: __________________

Address: ____
Street City Zip

Home Phone: ____________________________ Cell Phone: _____________________________
Do I have your permission to contact you via text message if necessary? Y N ____ (Initial here)

Status and length of time (for all that apply) :

Married ___________ Separated ___________ Divorced ___________ Single ___________

Widowed ___________ Living with Someone ____________ Employed Full-time ___________

Employed Part-time __________ Full-time Student ___________ Part-time Student ___________

Employment Information

Current Employer: ____ Hire Date/Year: _________

Title/Position: ____ Phone: __________________
Approximate Hours Worked Per Week: ____________ Does your job satisfy you? ________________

Nearest Relative (not living in your household):

Name: ___________________________________ Relationship to you: __________________________

Address: ____

Phone: _________________________ cell home work (circle one)

Medical Information

Primary Care Physician: _______________________________ Location: _____________________

Medications (include dosages, how frequently taken, and time of day it is taken):

____

____

List of current medical complaints/problems: ____

____

List of any family history of medical or mental health issues: __________________________________

____

Family Members Living in Household (continue on back if necessary):

Name: _____________________________ Age: ________ Relationship: _________________

Name: _____________________________ Age: ________ Relationship: _________________

Name: _____________________________ Age: ________ Relationship: _________________

Please list any of your children not living with you (include ages): ____________________

____

Reason for Seeking Counseling: ____

____

How long have you had this problem? _____________________

Any past therapy? Yes ___ No ___ If yes, name of previous therapist: ________________________

When? __________________ # of sessions? _____________________

How did you find my name (referral, my website, phone book, Psychology Today, other)**?**

____

Spiritual Beliefs: Protestant/Christian ____ Catholic ____ Jewish ____ Agnostic _____
Other: ______________________

Are you currently attending a place of worship? Yes ___ No ___

If yes, where you are currently attending? _________________________________

Did you grow up attending worship services? Yes ___ No ___

If yes, what denomination, church or synagogue? _________________________________