Ann Cunningham, M.A., LMFT 90583
Licensed Marriage and Family Therapist
9063 Foothills Blvd, Suite 4, Roseville, CA 95747
(916) 213-1835

CLIENT INTAKE FORM

GENERAL INFORMATION:

Name:_____
First MI Last

Spouse/Parent:_____
First MI Last

Street Address _____ Apt #_____

City _____State_____ Zip Code _____

List any separate address(es):_____

Client #1 Phone:_____
Home Cell Work

Client #2 Phone:_____
Home Cell Work

Indicate any restrictions on phone messages: _____

Date of Birth ___/___/___ Gender _____ Age_____ Parent/Guardian (under 18)_____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about us: _____ Referred by: _____

If a member of Magellan Insurance Network, provide a copy of your card & the following information:

INSURANCE INFORMATION: _____
Company Policy Number

_____
Subscriber Social Security Number Date of Birth

EMPLOYMENT/EDUCATION INFORMATION:

Full time employee Full time student Full time at home Part-time employee Unemployed

Place of employment/schooling:_____ Years/grade:_____

Type of work/schooling: _____Level of Education Completed: _____

MAKEUP OF YOUR CURRENT FAMILY:

____Single ____Engaged ____Married ____Separated ____Divorced ____Widow(er)

___ Cohabitating

Names & ages of Children: _____

BELIEF OR RELIGIOUS AFFILIATION:_____

FAMILY OF ORIGIN:

Parents: Mother: __ Living, age____; __ Deceased Father: __Living, age____; __ Deceased

Siblings: _____

THERAPY NEEDS:
Reason for seeking therapy at this time: _____

_____

Do you have thoughts of harming yourself or others? Yes/No, If Yes, please answer the following:
Are thoughts of harming yourself or others a frequent occurrence? Yes/No
Do you dwell on these thoughts or wonder if you can control them? Yes/No
Have you sought professional help because of these thoughts or feelings? Yes/No

Have you received psychotherapy or counseling in the past? Yes/No
When? _____ For what? _____

MEDICAL HISTORY:

Date of last medical examination: _____

Current physical illness or conditions: _____

Major surgeries or illnesses in the last five years: _____

Current medications and dosage: _____

Frequency of alcohol/drug usage: _____

Have you or any member of your family received help for drug or alcohol dependency? Yes/No
Who? _____ When? _____

PAYMENT METHOD: Check _____ Cash _____ Credit/Debit Card _____ Insurance _____

Client Signature:_____ Date: _____

Parent Signature for minor: _____ Date: _____