Care Counseling LLC
Christine Cunningham M.A., LMFT
Marriage and Family Therapist [License #01170]
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For Office Use Only:

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CC

Intake Information

Date:_____ Referral Source:_____

Primary Client(s):_____AGE:_____DOB:_____ SEX: M / F

2. Client_____AGE:_____DOB:_____SEX: M/F Rel to client:_____

3. Client_____AGE:_____DOB:_____SEX: M/F Rel to client:_____

Legal Guardian of client_____Relationship_____

Marital Status: Single/Married (# of years_____) ____Separated____Divorced_____Widowed
Address:_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Email Address(s) _____

Place of Employment/unemployed:_____ # of Months/ Years_____

Physician:_____Address:_____Phone: _____

Do you have any physical health problem: _____

_____

FINANCIAL RESPONSIBILITY INFORMATION (GUARANTOR)

Name of Responsible Party:_____

Guarantor Agreement: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by CHRISTINE CUNNINGHAM, M.A.,LMFT. This includes any event that results in the insurance provider not covering past sessions.

Sign_____Full Name_____Date_____

Insurance _____ Plan name _____

Primary Insured Full Name _____

ID#:_____ DOB Insured: _____ SS# of Insured_____

What brings you here today? _____
_____

What problems / symptoms are you experiencing? _____
_____
For How long? _____

List all family members living with client: _____
_____

Is the client currently taking any medication? Yes or No
If yes, please list DOSAGE AND FREQUENCY _____
_____

Previous counseling, Mental Health treatment or psychiatric hospitalizations with dates:
_____
_____
Was this a negative or positive experience? Please explain _____
_____

Please briefly describe your childhood experience? _____
_____
_____

Spiritual Affiliation if any_____

Military Affiliation if any _____Dates_____

What change are you looking to make in your life? _____
_____
_____

Notes
_____
_____
_____
_____
_____