Mark R. Cunningham, M.S., MFT-C
Adaptive Therapy LLC

Client __________

adaptivefamilytherapy@gmail.com

(970) 616-4890
1905 W. 8th Street
Loveland, CO 80537 Unit 202

Client Information Form

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully and ask questions if something is not clear. The information provided on this questionnaire is confidential and will not be released without your permission.

____
Name of Client

____
Address **City** **Zip**

______________________ OK to leave messages? ☐ Yes ☐ No
Primary Phone Number

______________________ OK to leave messages? ☐ Yes ☐ No
Alternate Phone Number

____
E-mail address (Scheduling or logistics only via e-mail. *Note: E-mail is not confidential)*

______________ ________ ______________________
Date of Birth **Age** **Race/Ethnicity**

______________ ______________ ______________
Relationship Status **Religion/Belief System** **Employment/Occupation**

Name of Family Members	Age	DOB	Relationship to Client

How many people live in your home, including yourself? _______

Emergency Contact Information

In case of an emergency, please list the name, address, and phone number of ***two*** *people who are* ***not*** *in therapy with you that I could contact.*

Contact #1 Name **Relationship to you** **Phone number**

Address **City/State**

Contact #2 Name **Relationship to you** **Phone number**

Address **City/State**

Please sign here as consent for your therapist to contact these individuals in an emergency, as deemed so by your therapist:

Signature **Date**

Medical History

Please answer the following questions to the best of your knowledge:

Physician **Phone** **Approximate Date of Last Visit**

Significant Medical Conditions/Diagnoses

Current Medications/Dosages

Please list type and amount of alcohol or drugs used currently:

Additionally, please describe any past or current problems with alcohol or drug abuse (including attempts to quit or cut down, past treatment, arrests, DUIs, etc.):

Other Relevant Information

If applicable, please describe your current spouse or partner:

____

Name **Gender** **Age** **Years/months together**

Do you feel safe in your current relationship?

Physically: □ Yes □ No

Emotionally: □ Yes □ No

Do your arguments escalate out of control? □ Never □ Rarely □ Occasionally □ Often

Have you previously received any previous outpatient therapy/counseling? □ Yes □ No

If yes, please describe briefly:

Have you previously had any hospitalizations? □ Yes □ No How many? ________

If yes, please describe briefly:

Please briefly describe any significant family events (i.e., deaths, moves, abuse, divorce, etc.)

What is happening in your life that resulted in this appointment?

What are you hoping to accomplish in therapy?

Who suggested you contact me?

Please add any additional information that you feel may be helpful to me

Please check any of the following symptoms that you or your family is currently experiencing:

- ☐ Nervousness
- ☐ Social anxiety/shyness
- ☐ Separation/divorce
- ☐ Anger/frustration
- ☐ Sleep disturbance
- ☐ Legal problems
- ☐ Too little energy
- ☐ Too much energy
- ☐ Loneliness
- ☐ Temper problems
- ☐ Parenting issues/arguments
- ☐ Depression
- ☐ Sexual problems
- ☐ Alcohol use
- ☐ Illegal drug use
- ☐ Prescription drug abuse
- ☐ Stress
- ☐ Headaches
- ☐ Memory problems
- ☐ Insomnia
- ☐ Feeling worthless
- ☐ Nightmares/night terrors
- ☐ Appetite (too much / little)
- ☐ Eating (too much / little)
- ☐ Suicidal attempts
- ☐ Suicidal thoughts
- ☐ Wanting to die
- ☐ Financial issues/arguments
- ☐ Unhappiness
- ☐ Tiredness/fatigue
- ☐ Decision making problems
- ☐ Physical health problems
- ☐ Death (of person / animal)
- ☐ Relationship problems
- ☐ Adoption issues
- ☐ Feeling you are not real
- ☐ Poor concentration
- ☐ Low self-esteem
- ☐ Hopelessness
- ☐ Guilt/shame
- ☐ Thoughts of hurting self
- ☐ Thoughts of hurting others
- ☐ Isolation/social withdrawal
- ☐ Grief/loss
- ☐ Anxiety/panic
- ☐ Heart pounding/racing
- ☐ Trembling/shaking
- ☐ Sweating
- ☐ Feeling things are not real
- ☐ Intrusive thoughts
- ☐ Defiance toward authority
- ☐ Argumentative
- ☐ Blackouts
- ☐ Fear of dying
- ☐ Fear of going crazy
- ☐ Can’t hold onto an idea
- ☐ Confusion
- ☐ Phobias/fears
- ☐ Easily agitated/irritated
- ☐ Delusions/hallucinations
- ☐ Obsessions/compulsions
- ☐ Gambling problem
- ☐ Shopping addiction
- ☐ Internet/gaming addiction
- ☐ Sexual addiction
- ☐ Pornography use/addiction
- ☐ Discrimination
- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Sexual assault
- ☐ Domestic partner abuse
- ☐ Feeling dirty
- ☐ Spiritual struggles
- ☐ Religious struggles
- ☐ Other: ________________

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Thank you for completing this questionnaire!