JIM CUNNINGHAM
Marriage, Family and Child Therapist License LMFT 77997

518 South Auburn Street
Grass Valley, CA 95945

Phone: (530) 277-3936
Fax: (530) 273-0098

CLIENT INFORMATION

Please provide the following information and answer questions below.
Please note: all information you provide is protected as confidential.

(PLEASE PRINT CLEARLY & USE BACK OF PAGE IF NEEDED)

Name____ Date_______________
(Last) (First) (Middle Initial)

Name of parent/guardian if under 18 years of age

____Relationship___________
(Last) (First) (Middle Initial)

Address____

City____State_____Zip________

Home Phone (____)____________________ May we leave a message? Yes ____ No____

Cell Phone (____)______________________ May we leave a message? Yes____ No ____

Work Phone (____)_____________________ May we leave a message? Yes____ No ____

Email (optional) ________________________ May we email you? Yes ____ No ____
(Please note: Email correspondence is not considered a confidential medium of communication)

Emergency contact:_________________________________ Phone:___________________

Age_____ Birthday____________________ Gender _____________

Occupation or Retired______________________________

Single ___ Married ___ Domestic Partnership ___ Separated ___ Divorced ___ Widowed ___

Please list children/ages____

____

Physician____Phone__________________

Referred by ____

Have you ever received any type of mental health services (psychotherapy, psychiatry, other)?

Yes ___ No ___ Please list practitioner(s) and modality ___________________________________

____

Are you currently taking any prescription medication? Yes___ No___

Please list: ____

____

Do you have any allergies to medications? Yes___ No ___ Please list: _______________________

____

Have you ever been prescribed psychiatric medication? Yes___ No ___

Please list: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health?

Very good ___ Good ___ Satisfactory ___ Unsatisfactory ___ Poor ___

Please describe any recurring health problems:____

____

Please list any specific sleep problems you are currently experiencing:

____

How many times per week do you generally exercise? _______

What types of exercise do you participate in? ____

Please list any difficulties you experience with your appetite or eating patterns: __________________

____

Are you currently experiencing overwhelming sadness, grief or depression? Yes ___ No ___

If yes, for approximately how long? ____

Please describe your experiences and when they began:_______________________________

____

Are you currently experiencing anxiety, panic attacks or phobias? Yes ___ No ___

Please describe your experiences and when they began:______________________________

____

Are you currently experiencing chronic pain? Yes___ No___ If yes, please describe: _________

____

Do you drink alcohol more than once a week? Yes___ No ___ How would you describe your use of alcohol? ____

Do you use recreational drugs? Daily___ Weekly___ Monthly___ Infrequently___ Never___

Please describe:____

Are you currently in a romantic relationship? Yes___ No___ For how long?__________________

On a scale of 1-10, how would you rate your relationship? _________________________________

What significant life changes or stressful events have you experienced recently? ________________

____

____

____

Can you briefly list important traumatic events in your life that still affect you today: ______________

____

____

Can you list important triumphant experiences in your life: _________________________________

____

____

FAMILY MENTAL HEALTH HISTORY

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (e.g. father, sister, uncle, grandmother)

Alcohol/substance abuse: Yes___ No___ Relationship___________________________________

Anxiety: Yes___ No___ Relationship____

Depression: Yes___ No___ Relationship____

Domestic violence: Yes___ No___ Relationship____

Eating disorders: Yes___ No___ Relationship____

Obesity: Yes___ No___ Relationship____

Obsessive compulsive behavior: Yes___ No___ Relationship________________________________

Schizophrenia: Yes___ No___ Relationship____

Suicide attempts: Yes___ No___ Relationship____

Other: Yes___ No___ Relationship____

ADDITIONAL INFORMATION

Are you currently employed? Yes___ No___ Retired? Yes___ No___

What is your current employment situation?_____________________________________

____

Do you enjoy your work? Yes___ No___ Is there anything stressful about your current work?

____

Do you consider yourself to be spiritual or religious? Yes___ No___

How would you describe your faith or beliefs? ______________________________________

____

____

What are the most important things in your life that you would either like to pursue or change?

____

____

____

What are you looking for in therapy?____

____

____

____

____

FINANCIAL OBLIGATIONS/CANCELLATION POLICY

I understand that payment in full is due at each session unless specific arrangements are made in advance, and that missed or cancelled appointments will incur a charge unless twenty-four (24) hour notice is given (except in the case of illness or emergency).

Date:____________________

Patient's Name (Please print):____

Signature:____
(Patient, or Patient's Parent/Guardian if under 18)

Relationship to Patient:____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions to harm, or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of that client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or that a child or vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Applicable Information
Information that may be requested includes, but is not limited to: types of services, dates/times of services, diagnosis, description of condition(s), treatment plan, progress of therapy, case notes, and summaries.

AGREEMENT

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____
Please print: Client's name (Parent/Guardian if under 18)

____ Date:__________________
Signature