Cunningham Counseling
1 Walpole Street, Suite 7
Norwood, MA 02062

Adult Information Sheet

Client Name: _____ Client DOB: _____

Ethnicity:_____ Gender: _____

Address: _____

Phone Numbers: _____ Email: _____

_____ Messages via phone, email & text: Y N

Employer:_____ Education Level: _____

Household Family Members: _____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

Emergency Contacts Name: _____ Name:_____

Phone:_____ Phone:_____

Relationship:_____ Relationship:_____

Reason for seeking counseling at this time:_____

_____

How did you hear about us?:_____

Have you seen a therapist in the last year? Y___ N___ If yes, how many sessions? _____

List any medication that you are currently prescribed _____

Allergies _____ Health Concerns _____

Primary Care Physician _____ Phone: _____

Psychiatrist (If Applicable) _____ Phone: _____

Insurance Information:

Insurance Provider: _____ Policy Number:_____

Policy Holder:_____ Relationship to subscriber:_____

Policy Holder DOB:_____ Co-pay Amount:_____ Deductible Met: Y___ N___

Allotted # of Sessions:_____

Any other information you would like the therapist to be aware of? _____

_____

Print Name Signature Date

Office Use:

Dx _____ Date_____ Signature _____