John Cutrone, LMHC, LLC
2000 Banks Rd., Ste. 217, Margate, FL 33063
Phone: (561) 289-9722 Fax: (561) 544-7149 Website: www.CutroneLMHC.com

Adult Client Information Form

Name: ____________ Date of Birth: ____________ SSN#: ____________

How do you Identify (Male, Female, Other - Describe): ____________

Address (Street, City, State, Zip): ____________

____

Home phone: ____________ Work phone: ____________ Cell Phone: ____________

Is it OK to contact you on these #'s? ☐ No ☐ Yes If Yes, which one(s)? ____________

Is it OK to email you?: ☐ No ☐ Yes If Yes, E-mail address: ____________

Birthplace: ____________ Marital/Relationship status: ____________

# of times married: ____________ # years in current marriage/partnership: ____________

Occupation: ____________

Employer: ____________

Education (Level/Degree): ____________

Spouse/Partner's name: ____________

Their Occupation: ____________ Their Employer: ____________

How many children do you have, if applicable?: ____________

Name: ____________ Age: ______ Currently living with you: ☐ No ☐ Yes

Name: ____________ Age: ______ Currently living with you: ☐ No ☐ Yes

Name: ____________ Age: ______ Currently living with you: ☐ No ☐ Yes

Name: ____________ Age: ______ Currently living with you: ☐ No ☐ Yes

Emergency Contact

Name: ____________ Relation: ____________ Phone Number: ____________

Address: ____________

Who referred you: ____________

Family doctor: ____________

List any major health problems: ____________

Please list any current medications/dosages: ____________

____

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Have you been to therapy before?: ☐ No ☐ Yes

If yes, when (List Approx Dates)?: ______

Who did you see?: ______

For what reason(s)?: ______

Did it help (explain)?: ______

Please **Check** any of the following reasons for coming to see me:

	ADDICTIONS		COPING SKILLS		GAMBLING		NO INTERESTS		SEXUAL PROBLEMS
	AGORAPHOBIA		CUTTING		GENDER IDENTITY		PAINFUL THOUGHTS		SLEEP
	ALCOHOL USE		DEPRESSION		HEADACHES		PANIC ATTACKS		STOMACH TROUBLE
	ANGER		DIVORCE		HEALTH PROBLEMS		PARENTING		STRESS
	ANXIETY		DRUG USE/ABUSE		HOMICIDAL		PHOBIAS		SUBSTANCE USE
	APPETITE		EDUCATION		IMPOTENCE		RELATIONSHIPS		SUICIDAL IDEATION
	BREAK-UP		ENERGY		INSOMNIA		SADNESS		TIREDNESS
	CAREER		EXTREME FATIGUE		LEGAL MATTERS		SELF-CONTROL		TRAUMA
	CHILD ABUSE		FEARS		LONELINESS		SELF-ESTEEM		VIOLENCE
	COMPULSIONS		FETISHES		MAKING DECISIONS		SELF-HARM		WEIGHT
	CONCENTRATION		FINANCES		MARRIAGE		SEXUAL ABUSE		WORK
	CONFIDENCE		FRIENDS		NERVOUSNESS		SEXUALITY		Other:

Briefly describe Current/other reason(s) for seeking or therapy: ______

______

______

Please be aware that full payment is expected at the time of your visit. I generally operate on time so please be prompt for your appointment as it will end at the original scheduled time, unless discussed.

Since your appointment time is reserved **exclusively for you**, the cancellation policy is as follows: **Appointments must be canceled 24 hours in advance. Appointments which are not given a 24 hour notice and/or missed appointments without cancellation will be subject to the full fee, as if the appointment was kept. Thank you for your cooperation.**

______ ______ ______

Printed Name of Client Signature of Client Date