

Nick Cutler Adolescents & Family Therapy, LLC

Client Information Sheet – Adult

Client's Legal Name: _____ Date of Birth _____ Age _____

Client's Preferred Name: _____ Gender Identity _____

Preferred Pronouns: _____ County of Residence _____

Home Address: _____

Email Address: _____

Phone Number(s) _____

May we leave messages at any/all of the above numbers? ☐ No ☐ Yes

Currently Employed ☐ No ☐ Yes If Yes, Occupation _____

Marital Status: ☐ Married ☐ Divorced ☐ Remarried ☐ Never Married ☐ Other

Emergency Contact (Name & Number) _____

Who referred you or how did you hear about this office?

☐ Social Services ☐ Court ☐ Primary Care Dr. ☐ Davidson County Mental Health ☐ Other:

Would you like to discuss additional services with a Victim Advocate? ☐ No ☐ Yes

In general, is your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Briefly describe your reason for seeking counseling:

Nick Cutler Adolescents & Family Therapy, LLC

Information / Symptom Checklist

Please help me provide the best possible care by answering these questions. Please mark which best fits your experience/feelings within the past month.

	Not at all	A little/ Sometimes	Often
1 Nervousness or shakiness	☐	☐	☐
2 Lack of interest in things you previously enjoyed	☐	☐	☐
3 Tires easily, has little energy	☐	☐	☐
4 Feeling everything is an effort	☐	☐	☐
5 Heart pounding or racing	☐	☐	☐
6 Feeling fearful/afraid	☐	☐	☐
7 Feeling sad/unhappy	☐	☐	☐
8 Feeling irritable/angry	☐	☐	☐
9 Feeling of hopelessness	☐	☐	☐
10 Trouble concentrating	☐	☐	☐
11 Increased anxiety	☐	☐	☐
12 Difficulty socially	☐	☐	☐
13 Difficulty at home	☐	☐	☐
14 Difficulty at work or school	☐	☐	☐
15 Having trouble sleeping	☐	☐	☐

Nick Cutler Adolescents & Family Therapy, LLC

Credit Card/Payment information

Client Legal Name: _____

Client Date of Birth: _____

Credit Card: _____
Name on Card Expiration

Billing Address Security Code

Account Number

Signature: _____ Date _____

Printed Name: _____

Relationship to Client: _____