

Cynthia Netting, M.Ed., LPC, NCC

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CONFIDENTIAL CLIENT INFORMATION

Date: _____

Name _____

Address _____

Date of Birth _____ Age _____ Email address: _____

Main Phone _____ circle one: cell home work

Alternate Phone _____ circle one: cell home work

Occupation _____ Employer _____

Relationship Status:

Single Engaged Married Separated Divorced Widowed Partnered

Previous Mental Health Treatment:

Please list any psychiatrists, therapists, hospitals, self-help groups, and residential treatment centers, and the issues for which you were seen. _____

Describe any health concerns: _____

List drugs/medications you presently use and what they are prescribed for: _____

How were you referred to me? (check all that apply)

____ Doctor Referral - _____
(name)

____ Friend/Family - _____
(name)

____ Psychology Today website

____ Yelp

____ Other website _____
(name)

FAMILY MENTAL HEALTH HISTORY

If YES, please check the box for all applicable family members

	NO ONE	Mother	Father	Sisters	Brothers	Cousins	Aunt/Uncle	Grandparents
Depression								
Bipolar Disorder								
Anxiety/Panic Disorder								
Eating Disorder								
ADD/ADHD								
Post-traumatic Stress Disorder (PTSD)								
Obsessive-Compulsive Disorder								
Borderline Personality Disorder								
Schizophrenia or Psychosis								
Alcohol or Other Substance Abuse								

Other family mental health information: _____
