Jennifer Davis, MA, MFT
Profound Impact Therapy
MFC# 49934
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Jdavis@profoundimpactmft.com

1Name_____ Date_____

Address _____City_____ Zip_____

Home phone _____Cell phone _____E-mail _____

OTHER PARTIES INVOLVED:

2Name_____

Home phone _____Cell phone _____E-mail _____

OK to leave message? ☐Yes ☐No Ok to text? ☐Yes ☐No

1Age _____ Date of birth _____ 2Age _____ Date of birth _____

Names and ages of children_____

Who lives in the household? _____

What issues/concerns cause you to seek treatment? Please describe_____

_____

_____

Previous Therapy? ☐Yes ☐No When? _____

Why? _____

Name of treating therapist(s)_____

Would you consent for me, Jennifer Davis, MFT to contact him/her? ☐Yes ☐No

Are either of you on medication? ☐Yes ☐No Who?

_____

What? _____ Dosage? _____Prescribed by? _____

Are you using Medical Marijuana? ☐Yes ☐No

Do you or any member of your family have a problem with: ☐ Drugs ☐Alcohol ☐Gambling

In recovery? ☐Yes ☐No

Are you or any member of your family having suicidal thoughts or serious thoughts about harming another? ☐Yes ☐No Who? _____ Any Plan? ☐Yes ☐No

Include any other information that you believe is relevant to your mental health treatment

_____

_____

List any troublesome or significant medical conditions? _____

_____

Who referred you? _____