

**Jennifer Davis, MA, MFT**  
**Profound Impact Therapy**

MFC# 49934

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925-298-7172

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Name \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail \_\_\_\_\_

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

Age \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Names and ages of children \_\_\_\_\_

Who lives in the household? \_\_\_\_\_

Custody Status (if applicable) \_\_\_\_\_

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? \_\_\_\_\_