Jennifer Davis, MA, MFT
Profound Impact Therapy
MFC# 49934
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Name ______________________________ Date ______________________

Address ______________________ City ________________ Zip __________

Home phone ____________ Cell phone ____________ E-mail ________________

OTHER PARTIES INVOLVED:

Name 2 ______________ Name 3 ______________ Name 4 ______________

Phone 2 ______________ Phone 3 ______________ Phone 4 ______________

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

Age _____ Date of birth ___________ Age _____ Date of birth ___________

Age _____ Date of birth ___________ Age _____ Date of birth ___________

Names and ages of children ____

Who lives in the household? ____

____

What issues/concerns cause you to seek treatment? Please describe ____________

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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

Any of the above 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

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List any troublesome or significant medical conditions? ______________________

____

Who referred you? ____