Meg Luce, MS, LMFT
Licensed Marriage and Family Therapist
License #MFC 47613

CLIENT INFORMATION **Today's Date ______________**

Name______________________________________ Birthdate ________________ Age______

Street Address ____

City ______________________________ State _____ Zip __________

Home Phone (____)___________________ Work Phone (____)_________________________

Email_______________________________ *please note, email may not be confidential

Cell Phone (____) _______________Circle best contact number. Discreet message OK? Y / N

Car make and License Number (emergency info)____

Education _______________________________ Occupation ___________________________

Second Client (spouse, partner, or Responsible Party)

Name:____Birthdate______________Age______

Address (if different)_____________________________________ Phone _________________

Cell Phone (____) _______________Circle best contact number. Discreet message OK? Y / N

Email_______________________________ *please note, email may not be confidential

Car make and License Number (emergency info)____

Education _______________________________ Occupation ___________________________

Marital Status: Single, Shared living, Married, Divorced, Widowed **Yrs. Together _______________**

Current Household Members (Name, Birth date, Age, Relationship):

____ ________________________________

____ ________________________________

____ ________________________________

For clients under 18, School _____________________________________ Grade __________

Emergency Contact Information:

Name of Contact __________________________ Phone (___)_____________relation_______

Referred by_________________________________

For what concern(s) are you seeking counseling at this time?

Previous counseling? If so, with whom?____

	Yes / No	**Approx. Date(s)**________________	**Duration**_____________
Second client	**Yes / No**	**Approx. Date(s)**________________	**Duration**_____________

Psychiatric hospitalization?	**Yes / No**	**Approx. Date(s)**______________	**Duration**__________
Second client	**Yes / No**	**Approx. Date(s)**______________	**Duration**__________

Psychiatrist's Name________________________________ **phone** ____________________________

(Second client)____________________________________ phone ____________________________

Gen. Practitioner's Name______________________________**phone**________________________

(Second client)____phone________________________

Current medical conditions____

(Second client)____

Current medications____

(**Second client)**____

Please check those that apply: (use initials if more than one party)

__Depressed mood	__Eating disturbance
__Physical abuse	__Hallucinations
__Low self-esteem	__Phobias/fears
__Chronic pain	__Trauma
__Panic attacks	__Anger/temper
__Anxiety	__Alcohol/drug use
__Sleep disturbance	__Sexual abuse
__Aggressive behaviors	__Suicidal thoughts
__Homicidal thoughts	__High stress
__Social skills problems	__Relationship issues
__Low energy/fatigue	__Sexual disturbance
__Obsessive/Compulsive	__ Past Substance Abuse (type)__________________
__Manic Episodes	__Present Substance Abuse (type)________________
__Other ______________	__Gender Issues