CLIENT INFORMATION
Megan Carlson, MA, LPC, Ltd

Name: **Date of Birth**:
Pronouns:

Address:

Home Phone: May I leave a message? ☐Yes ☐No
Cell Phone: May I leave a message? ☐Yes ☐No
May I text you? ☐Yes ☐No
Email Address: May I email you? ☐Yes ☐No

Name of Parent/Guardian (If under the age of 18):
Parent/Guardian Phone Number:

Marital Status: ☐Never Married ☐Married ☐Separated ☐Divorced ☐Widowed
☐Civil Union/Domestic Partnership ☐Boyfriend/Girlfriend

Gender: **Sexual Orientation** (Optional):

Who do you live with?

Referred By:

Please provide 1-2 emergency contacts and their numbers. Reasons they would be called include medical emergencies or if client may be a danger to self:
Emergency Contact Name: **Phone Number**:
Emergency Contact Name: **Phone Number**:

Current Therapist's Name (If applicable):
Phone Number:
Current Psychiatrist's Name (If applicable):
Phone Number:

Why are you seeking treatment?

Client Signature: _____
Date: