Client Information

Client Name:_____ Date:_____

Home Address:_____

_____

Age: _____ Date of Birth: _____ S.S.N. _____

Occupation: _____

Marital Status: Single Married Widow(er) Divorced Separated Partnered

If applicable, partner/spouse name: _____

Do you have children? Yes No

If yes, names and ages: _____

Preferred Phone Number: _____ Is this a mobile number? Yes No

Secondary Phone Number: _____ Is this a mobile number? Yes No

May I leave a voice mail message for you on your preferred phone number? Yes No

Email address: _____

How do you prefer to be contacted? Primary Number Secondary Number Email

Emergency contact:_____

Emergency contact phone number:_____

Molly LaCroix, LMFT
Licensed Marriage & Family Therapist

PO Box 8373 Bend, OR 97708
(858) 888-9623
molly@mollylacroixtherapy.com
CA License MFC #51106
OR License #T1544

Client Information (con't)

Have you ever seen a therapist or other mental health professional? Yes No

If yes, please briefly list the reason(s): _____

_____

Are you taking any psychotropic medications (medications for mental health)? Yes No

If yes, please list them_____

What brings you to therapy at this time?_____

_____

_____

Signature: _____ Date: _____

Printed Name: _____

Molly LaCroix, LMFT
Licensed Marriage & Family Therapist

PO Box 8373 Bend, OR 97708
(858) 888-9623
molly@mollylacroixtherapy.com
CA License MFC #51106
OR License #T1544