**CLIENT INFORMATION**

**Megan Carlson, MA, LPC, Ltd**

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

**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**: