MERCER Medicine
Feel better. Live better.

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GA Lic. Marriage and Family Therapist #: MFT001317
Certified LGBT Psychotherapy Provider, Certified Family Life Educator

Client Demographic Form

Client Information form for… **TODAY'S DATE:_____**

First Name | Last Name | Birthday | Ethnicity

Primary Contact Information

Primary Phone | Secondary Phone | Primary Email Address

Street Address | City | State | Zip

I prefer to be contacted via (please circle): Phone Email Regular Mail

Emergency Contact

First Name | Last Name

Relation | Phone Number

Family Doctor

First Name | Last Name

Office | Phone Number

Briefly, what has made you seek therapy?

Have you ever been in therapy for this or anything else before? Yes No

Are you on any medication? Yes No
If yes, please list what medication and what for.

Med1 | Med 2

Med 3 | Med 4

Please check items in the list that you or your family have a history of or are currently suffering from (or experienced):

- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Emotional Abuse
- ☐ Mental Abuse
- ☐ Rape
- ☐ Sexual Problems
- ☐ Substance Abuse/Addiction
- ☐ Depression
- ☐ Anxiety
- ☐ Personality Disorder
- ☐ Eating Disorder
- ☐ Suicide / Suicidal Thoughts
- ☐ Death/Greif
- ☐ Chronic medical Illness
- ☐ Self Esteem Issues
- ☐ Divorce
- ☐ Domestic Violence
- ☐ Legal Problems
- ☐ Social Phobia
- ☐ Learning Disability

Is there anything else you feel your therapist should know?