



Marci Danielson, M.S., LAMFT
Confidential Client Intake Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____
Leave message? []Yes []No Leave message? []Yes []No

Work Phone: _____ Email: _____
Leave message? []Yes []No Contact by email? []Yes []No

Occupation: _____ Best time/day to contact you: _____

Birth date: _____ Age: _____ Marital Status: [] Single [] Married [] Divorced [] Separated

Education Level: [] 8th Grade or Below [] High School [] Some College [] Associates [] Bachelors [] Masters [] Doctorate

Have you been in counseling/therapy before? []Yes []No If yes, when: _____ Did it help? []Yes [] Some []No

Reason for therapy? _____

Have you or a family member ever attempted suicide? _____

Please list all medications you take: _____

Physician's Name: _____ Phone number: _____

Psychiatrist's Name: _____ Phone number: _____

Do you have any physical disabilities or chronic illnesses? (please list): _____

Please circle any of the following that are currently troubling you:

- Alcohol/Drug use, Self-Esteem, Assertiveness, Addiction, Appearance/Weight, Expressing Feelings, Grief/Loss, Meeting People/Friends, Guilt, Homesickness, Eating Problems, Sexuality, Suicidal Thoughts, Alcohol or Drug Issues, Depression/Sadness, Anxiety/Panic, Worry/Fear, Anger/Rage, Helplessness, Stalking, Physical Abuse, Verbal Abuse, Sexual Abuse, Marriage/Spouse/Partner, Loneliness, Perfectionist, Shyness, Sleep, GLBT issues, Trust, Communication with Partner, Sexual Harassment, Stress, Spiritual/Religious, Work Stress, Money/Financial Issues, Childhood Issues, PTSD, Boredom, Relationship issues, Motivation, School/Educational, Dating, Career, Time Management, Hopelessness, Divorce/Break up, Parenting, Traumatic Event, Family

1) Emergency Contact: _____ Relationship: _____ Phone: _____

2) Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about Synchronicity Counseling? _____