

Maggie Vaughan, MFT, Ph.D.

CA Lic#: MFC 42891; NY Lic#: MFT 983

SCREENING INFORMATION

Date _____

Client's First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Is it ok for Dr. Vaughan to send mail to this address? (check one): yes no

Telephone (Home) _____

Is it ok for Dr. Vaughan to leave voicemail? yes no

(Work) _____

Is it ok for Dr. Vaughan to leave voicemail? yes no

(Mobile) _____

Is it ok for Dr. Vaughan to leave voicemail? yes no Ok to leave text messages? yes no

Email _____

Is it ok for Dr. Vaughan to send email? (check one): yes no

Birthdate ___ / ___ / ___ Age _____ Gender ___F___M

Name of Spouse/Guardian _____ Phone _____

Address _____

City _____ State _____ Zip _____

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Emergency Information

In case of emergency, contact:

Name _____ Relationship _____ Phone _____

Address _____

City _____ State _____ Zip _____

Physician _____ Phone _____

Address _____

City _____ State _____ Zip _____

Psychiatrist _____ Phone _____

Address _____

City _____ State _____ Zip _____

Other Physicians _____ Phone _____

Current Medications/Reasons _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Employer _____ Phone _____

Referral Source

How did you hear of Maggie Vaughan, MFT, Ph.D. (or from whom)? _____