

## Confidential Client Information and Intake Form

John Porterfield, MFT, JA (MFC 35445)

Client's Name

Birth Dale

Street Address

City

State

Zip Code

Home Phone

Cell Phone

Email address

You have permission to contact me on my

Home Phone  Cell Phone

Referral Source

Person

### Employment

Occupation

Length of time there:

Responsibilities

Do you like your work?

- Yes  No  In between

**Personal Information**

Marital Status

- Single  Living Together  Married  Partnered  Separated  Divorced

Brief Relationship History

Names/Ages of Children (if any)

Parents

- Both alive  Both deceased  One parent deceased

Siblings/ages (if any)

Emergency Contact (name, relationship, phone number)

**Financial Information**

Preferred Payment

- Paypal  Check

I will need a monthly claim form for insurance reimbursement

- Yes  No

**Confidential Psychological and Medical History**

Have you previously been in psychotherapy and counseling? If so, when?

For how long?

For what purpose(s)?

Results

Please list any previous or current medications you have taken for psychological purposes

Please list all prescription medicines you are currently taking

If you have had difficulties with any of the following, current or past, please check off and explain in the box below

- |  |  |
|--|--|
| <input type="checkbox"/> Alcohol, drug, or tobacco dependence or frequent use? | <input type="checkbox"/> Major illness, surgery or physical problems?                      |
| <input type="checkbox"/> Eating disorder(s)                                    | <input type="checkbox"/> Anger issues, domestic violence (current or childhood)?           |
| <input type="checkbox"/> Other addictive or compulsive behavior(s)?            | <input type="checkbox"/> Marital, relationship, or family problems (current or childhood)? |
| <input type="checkbox"/> Depression or suicidal thoughts/attempts?             | <input type="checkbox"/> Learning disabilities/problems or ADD/ADHD?                       |
| <input type="checkbox"/> Anxiety or panic attacks?                             |  |

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List stressful situations in your life (accident, hospitalizations, relationships, traumatic events)

What brings you into therapy at this time?

What do you hope to achieve from therapy?

Other useful information to assist in counseling

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