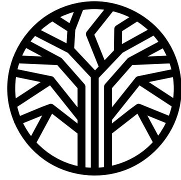

Laura Petiford
PMHNP, LMFT
A FRESH APPROACH TO MENTAL HEALTH

Client Intake Form

Date:_______________

Name:________________________________ Client's Date of Birth____________________

Address:____

City:________________________ State:__________Zip:_____________________________

Telephone Numbers:

Home:____________________Cell:___________________Work:______________________

Email:__________________________ Emergency Contact:__________________________

Referral Source:____

Brief Description of the Presenting Problem:

____

____

____

____

Previous Treatment:

Inpatient: ____

Outpatient:____

Please list all medications taken by the client:

Medication Name	Dosage	Prescriber

Marital Status__________________Highest Grade Completed: _____________________

Employer/School:__________________________ Race/Ethnicity:____________________

Primary language at home:___________________ Spiritual Preference:_________________

Release of Information to speak to the following individuals or health care providers:

Name_________________________________ phone__________________________

__________________________________ phone__________________________

___________________________________ phone__________________________

______________________________________ ____________________________

Signature Date

*This release expires in 2 years from date of signature or upon request. Verbal release of information is for the purpose of coordination of treatment only.