

MICHAEL J. GIALANELLA, MS, LMFT
North Carolina Family Therapy Center, PLLC
8522 Six Forks Road, Suite 103 Raleigh, NC 27615



Tel: 919.247.9359 michael@ncftc.org

## **Intake Information**

Name:				Source of	f Referral:		
Address:			May I contact the referral? ☐ Yes ☐ No				
				Date of B	Birth: / /	Age:	
Cell Phone:				Work Pho	Work Phone:		
Home Phone:				Email:	Email:		
Which is the best way t	o conta	ct you?   Home	e 🗆 Wo	rk [	□ Cell □ Emai	ıl	
Preferred method of payment: ☐ Cash		□ Check	□ Credit/Debit card				
*Please note that if   emergency tele-ther			eck, a card will	be expect	ted to be on file in ca	ase of cancellations or	
Type of therapy seeking	g:	□ Individual	☐ Couple	☐ Family			
Relationship Status:		☐ Single	□ Dating	☐ Cohabiting ☐ Married			
		□ Separated	□ Divorced	□ Widow	ed □ Other		
Grade/Occupation:		So	chool/Emplo	oyer:			
Highest education level	: □ K-8	☐ High School	☐ Some Colleg	e 🗆 Bachelo	or's degree □ Grad. de	gree/Advanced training	
Please provide the follo with you):	wing inf	formation for each	ch person currer	ntly living in	your household (even	if not attending therapy	
Full Name Ger		er	Age		Relationship to Client		
						_	
Please provide the follo significant role in your I	wing inf	formation for oth	ner family memb	ers <i>not</i> curi	rently living in your hou	usehold but who play a	
Full Name	Gende		Age	archer grant	Relationship to Client	State of Residence	
			_				



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## **Intake Information**

Are you currently taking any prescription medications? ☐ Yes ☐ No							
If yes, which medication(s) and why?							
Are you currently using illegal drugs and/or drinking excessive amounts of alcohol? $\square$ Yes $\square$ No							
If currently using illegal drugs, which drugs and how often?							
If currently drinking excessive amounts of alcohol, how many drinks on average per day?							
Are there any legal actions pending (criminal or civil)? $\square$ Yes $\square$ No							
If yes, please describe:							
Are you in any danger of abuse, suicide, or homicide? $\square$ Yes $\square$ No							
If yes, please describe:							
Have you received therapy in the past? □ Yes □ No							
If yes, please describe type, duration, and for what reasons?							
Have you received any psychological diagnoses?  ☐ Yes ☐ No							
If yes, which ones and when?							
Do you have any physical health problems or concerns? ☐ Yes ☐ No							
If yes, please describe:							
Please help me understand what you (and your family) would like to be doing differently:							
1)							
2)							
3)							



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Client/Guardian Name

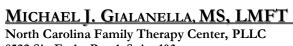
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## **Intake Information**

Emergency Contacts			
Name:			
Relationship to You:			
Day Phone:			
Evening Phone:			
Name:			
Relationship to You:			
Day Phone:			
Evening Phone:			
enter therapy). I affirm that pri understand the nature of thera	ior to becoming a client of Michael py, including the possible risks and tions and have had my questions a	J. Gialanella, MS, LMFT he gave i d benefits. I understand his office	policies and procedures. I have
Client/Guardian Name	Signature		
Client/Guardian Name	Signature	 Date	

Signature

Date



rtth

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## **AUTHORIZATION FOR CREDIT CARD PAYMENT**

Name(s) of Client(s):	
Cardholder's Name (exactly as it appears):	
Cardholder's Billing Address:	
Type of card: ☐ Visa ☐ MasterCard ☐ Ar	American Express
Credit card number:	
Expiration date:/	
CVV Number (3-digit code on back):	
Email where you would like receipt sent:	
Family Therapy Center, PLLC, or if the above named client(s provide at least 24 hours cancellation notice and the appoint initially scheduled appointment. I understand that the full see	tes to my credit card within 72 hours (or unless arraigned rapy session with a licensed therapist from the North Carolina (s) is unable to attend a scheduled session and does not interest cannot be rescheduled in the same week as the session fee will be charged even if the above named client(s) restand that I am responsible for having a sufficient credit line d by the North Carolina Family Therapy Center, PLLC due to swill appear on my credit card statement as NCFTC sent remination of therapy and when the above named client's
Signature of Cardholder	Date