

Tel: 919.247.9359

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

michael@ncftc.org

## **Intake Information**

Name:				Source of	of Refe	rral:		
Address:				May I contact the referral? $\square$ Yes $\square$ No				
				Date of	Birth: _	//	Age:	
Cell Phone:				Work Ph	none: _		_	
Home Phone:					Email:			
Which is the best way to contact you? ☐ Home ☐ Wor				·k	□ Cell	☐ Email		
Preferred method of payment: ☐ Cash			□ Check	□ Credi	t/Debit	card		
*Please note that if personal tele-there			ck, a card will	be exped	cted to	be on file in cas	se of cancellations or	
Type of therapy seeking:		☐ Individual	□ Couple	□ Famil	у			
Relationship Status:		☐ Single	□ Dating	□ Cohal	biting	☐ Married		
		☐ Separated	□ Divorced	□ Wido	wed	☐ Other		
Grade/Occupation:			Scl	hool/Empl	oyer: _			
Highest education level:	: □ K-8	☐ High School	☐ Some College	e □ Bache	lor's de	egree □ Grad. deg	ree/Advanced training	
Please provide the followith you):	wing inf	ormation for eac	h person curren	tly living i	n your	household (even if	not attending therapy	
Full Name Ger		r	Age	Relat		ionship to Client		
Please provide the following significant role in your li							sehold but who play a	
Full Name	Gende	er e	Age		Relati	ionship 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? ☐ Yes ☐ 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)

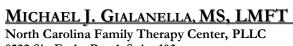


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## **Intake Information**

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 Michae py, including the possible risks an tions and have had my questions	l J. Gialanella, MS, LMFT he gave d benefits. I understand his offic	
Client/Guardian Name	Signature	Date	
Client/Guardian Name	Signature	Date	
Client/Guardian Name	Signature	 Date	<u> </u>



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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	☐ American Express	□ Discover
Credit card number:			
Expiration date:/			
CVV Number (3-digit code or	n back):		
Email where you would like i	receipt sent:		
(squareup.com) to charge the otherwise) after the above of Family Therapy Center, PLLC provide at least 24 hours carbonially scheduled appointment arrives to a session late or leavailable, and that I am resprejected credit card transactions.	ne predetermined fee from the predetermined fee from the above name ancellation notice and the feat. I understand that eaves the session early ponsible for all charges ions. I understand that the feat is a understand that ithorization will expire	for services to my credit card with a lice of a therapy session with a lice of client(s) is unable to attend a neappointment cannot be rescribed full session fee will be charged. I understand that I am responsincurred by the North Carolina the charges will appear on my creupon termination of therapy an	Center, PLLC and Square Register thin 72 hours (or unless arraigned ensed therapist from the North Carolina a scheduled session and does not neduled in the same week as the ged even if the above named client(s) nsible for having a sufficient credit line Family Therapy Center, PLLC due to dit card statement as NCFTC sent d when the above named client's
Signature of Cardholder		Date	