MICHAEL J. GIALANELLA, MS, LMFT
North Carolina Family Therapy Center, PLLC
8524 Six Forks Road, Suite 101
Raleigh, NC 27615
Tel: 919.247.9359
michael@ncftc.org

Intake Information

Name: _____ Source of Referral: _____

Address: _____ May I contact the referral? ☐ Yes ☐ No

_____ Date of Birth: ___ /___ /___ Age: ___

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Email: _____

Which is the best way to contact you? ☐ Home ☐ Work ☐ Cell ☐ Email

Preferred method of payment: ☐ Cash ☐ Check ☐ Credit/Debit card

***Please note that if paying by cash or check, a card will be expected to be on file in case of cancellations or emergency tele-therapy sessions**

Type of therapy seeking: ☐ Individual ☐ Couple ☐ Family

Relationship Status: ☐ Single ☐ Dating ☐ Cohabiting ☐ Married

☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Grade/Occupation: _____ School/Employer: _____

Highest education level: ☐ K-8 ☐ High School ☐ Some College ☐ Bachelor's degree ☐ Grad. degree/Advanced training

Please provide the following information for each person currently living in your household (even if not attending therapy with you):

Full Name	Gender	Age	Relationship to Client

Please provide the following information for other family members *not* currently living in your household but who play a significant role in your life (e.g. friend, partner, sibling, child, parent, grandparent etc.):

Full Name	Gender	Age	Relationship to Client	State of Residence

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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)? ☐ Yes ☐ No

If yes, please describe: _____

Are you in any danger of abuse, suicide, or homicide? ☐ Yes ☐ 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: _____

My signature below affirms my informed and voluntary consent to enter therapy (and/or have my child/ren or other family members enter therapy). I affirm that prior to becoming a client of Michael J. Gialanella, MS, LMFT he gave me sufficient information to understand the nature of therapy, including the possible risks and benefits. I understand his office policies and procedures. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that I can ask questions and raise concerns about the treatment at any time.

_____	_____	_____
Client/Guardian Name	Signature	Date
_____	_____	_____
Client/Guardian Name	Signature	Date
_____	_____	_____
Client/Guardian Name	Signature	Date

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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 on back): _____

Email where you would like receipt sent: _____

My signature below indicates that I authorize the North Carolina Family Therapy Center, PLLC and Square Register (squareup.com) to charge the predetermined fee for services to my credit card within 72 hours (or unless arraigned otherwise) after the above named client(s) meets for a therapy session with a licensed therapist from the North Carolina Family Therapy Center, PLLC, or if the above named client(s) is unable to attend a scheduled session and does not provide at least 24 hours cancellation notice and the appointment cannot be rescheduled in the same week as the initially scheduled appointment. I understand that the full session fee will be charged even if the above named client(s) arrives to a session late or leaves the session early. I understand that I am responsible for having a sufficient credit line available, and that I am responsible for all charges incurred by the North Carolina Family Therapy Center, PLLC due to rejected credit card transactions. I understand that charges will appear on my credit card statement as NCFTC sent from info@ncftc.org. This authorization will expire upon termination of therapy and when the above named client's account with the North Carolina Family Therapy Center, PLLC, is settled.

_____ _____
Signature of Cardholder Date