Redding Counseling, LLC
Lenore Pranzo, MA, LMFT, Cht, PhD

Client Intake Form

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Is it ok to leave message?: _____

Alternate Phone: _____ Is it ok to leave message? _____

Emergency Contact Name: _____ Phone: _____

Email _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Employer/School: _____ Highest Grade Completed: _____

Primary Language Spoken at home: _____ Spiritual Preference: _____

Referral Source: _____ Is it OK to thank them? _____

Household Composition

Adults/Male or Female	First Name	Last Name	DOB	Marital Status

Children	First Name	Last Name	DOB	Relationship	Gender	Primary Residence
1st						
2nd						
3rd						
4th						

Insurance Information – Fill out if haven't given card for copy

Primary Insurance: _____ **ID#** _____

Group # _____ **Telephone:** _____

Carrier: _____ **DOB:** _____

Secondary Insurance: _____ **ID#** _____

Group # _____ **Telephone:** _____

Carrier: _____ **DOB:** _____

Description of the presenting problem:

_____

_____

_____

_____

Previous treatment including substance abuse treatment:
Inpatient:

Outpatient:

What did you feel was helpful from previous treatment(s) and what wasn't helpful:

What outcomes do you want from therapy?

What have you tried to do for this problem?

Do you have any health issues or concerns?

List all medications taken by client:

Medication	Dosage	Prescribing physician

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Appointment Cancellation and Financial Agreement

First name: **Last Name:**

Each meeting is another opportunity to help you confidentially take charge and start living the life that is important to you. It is understood that things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, **24-hour notice** is required. Please understand that the time is set aside for you, and if you are unable to make it, there is a missed opportunity to meet with another valuable client. This policy is in place to give enough time to schedule another client in that time slot. If you fail to cancel without giving 24 hours prior to your appointment, a $50 fee will be charged to the card below.

I authorize the following card to be used for co-pays and fees incurred during the time I am a client with Redding Counseling, LLC.

Card Number _____

Expires _____ CVV _____

Printed Name _____

Signature _____ Date _____

I understand that the office of Redding Counseling, LLC will attempt to bill my insurance, however, **if my insurance does not pay, for whatever reason, I am responsible for any remaining balance.** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency, I will call 911 or go to the nearest hospital.
- I will adhere to the cancellation guidelines above to the best of my ability.

Client Name (Please Print) _____

Client/Guardian signature _____ Date _____