CLIENT INTAKE INFORMATION

Julie Ray Counseling

Licensed Marriage & Family Therapist

PERSONAL INFORMATION

Full Name ______________________________ DOB ____________ Today's Date _____________________
Address _______________________________________ City ___________________ State ____ Zip _______
Home Phone ____________________ Cell Phone ____________________ Other Contacts _______________
Referral Source _________________________________ E-mail _____________________________________
Employer ____
Employer's Address ______________________________ City __________________ State ____ Zip _______
If under 18, give names of parents or guardian ____
School ________________________________ Grade _______________ Teacher _______________________

INSURANCE INFORMATION

Responsible Party ____ Date of Birth ___________________
Address _______________________________________ City _______________ State ______ Zip __________
Phone # (home) ________________________________ Employer ____
Relationship to Client ___________________________ SS# ____
Insurance Company _____________________________ Policy # ______________________________________
Ins. Co. Phone # _______________________________ Group # _______________________________________

PERMISSION TO LEAVE MESSAGE

I DO_____ I DO NOT____ wish for messages to be left when necessary with a person or voice message.
I prefer messages to be sent via TEXT_____ and or VOICEMAIL_____
Please only the phone numbers you would like to be used for reminder calls.
Cell Phone number:______________________ Home Phone number:______________________________
Work Phone number:_____________________ Other Phone number:______________________________

MEDICAL INFORMATION

Physician's Name ____ Date of last exam ______________
Current Medications ____
Medical Conditions ____
Please list any alcohol or drug use or abuse ____
Any difficulties in normal childhood development? □ Yes □ No If yes, please explain

____

Personal or family medical history: (please check all that apply)
□ Epilepsy □ Seizures □ Stroke □ Thyroid □ Autism □ Mental Retardation □ Alcoholism
□ Depression □ Anxiety □ Bipolar □ ADHD □ Drug Addiction □ Schizophrenia □ OCD
□ Completed Suicides; who _______________________________ when ______________________________

FAMILY INFORMATION

List others living in your home (check box if they will be in counseling with you)

Name		Age	Relationship
________________________________	□	_________	________________________
________________________________	□	_________	________________________
________________________________	□	_________	________________________
________________________________	□	_________	________________________

Julie Ray Counseling PLLC

100 Maple St. Ste. C, Cashmere, WA 98815

Phone (509) 557-0178

CLIENT INTAKE INFORMATION

Marital Status: (circle one) Single Married Separated Divorced Widowed
If married: Date married ________________ Name of Spouse ____

COUNSELING INFORMATION

Prior counseling received:
Therapist ___________________________ Approx. time frame _______ Reason ____________________________
Therapist ___________________________ Approx. time frame _______ Reason ____________________________
Briefly describe the current problem that brought you here today?

____
____
____
____

Have you previously experienced this same condition? □ Yes □ No If yes, give time frame _______________
What do you hope to accomplish through therapy? ____
____
____
Family strengths and support networks ____
____
Any additional information that may be helpful ____
____
Have you been thinking about harming yourself or others in the last six months? □ Yes □ No If yes, when did you last think of harming yourself? ___________________________ Have you attempted suicide in the past and/or have you been hospitalized in a psychiatric facility? □ Yes □ No
If yes, give time frame and name of hospital ____
Legal Issues ____

TERMS & CONDITIONS: Julie Ray MS, LMFT is a private, clinical service provider. Clinical service fees are provided by private payment. Julie Ray Counseling PLLC., will electronically bill primary insurance providers, secondary insurance billing will be your responsibility. Payment of CASH or CHECK is expected at the time of service. If your personal check is returned for non-sufficient funds (NSF), a **service fee of $30.00** will be added to the face value of the NSF check. If this account should become delinquent, it will be **subject to collection** with any costs or fees resulting therefrom to be paid by you, including, but not limited to court costs and attorney fees. **Julie Ray Counseling PLLC, reserves the right to charge the full clinical fee of $150 for any session that is canceled with less than 24 hours notice, unless prior arrangements have been made.** 50-60 Minute sessions are billed $150. Please refer to the Informed Consent Notice for further clarification on billing.
The signature below acknowledges that the client has read and agrees to the above terms and conditions.

____
Signature of Client (parental consent needed for 12 and under) **Date**

(THERAPIST USE ONLY)
☐ **Full Mental Health Assessment Completed** **(therapist initials)**

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