Confidential Client Intake Form

Primary Contact Information

First Name _____ Middle Initial_____

Last Name _____

I am seeking services for: ☐ myself ☐ my partner and I

☐ my child *(Please Complete and Attach Confidential Child Intake Form)*

Primary Address _____

City _____ State_____

Zip _____ County _____

It is okay to contact me via:

☐ Home Phone _____

☐ Mobile Phone _____

☐ Email_____

Primary Client Information

Age_____ Date of Birth_____

Social Security Number _____

Gender: ☐ Male ☐ Female ☐ Other

Preferred Gender Pronoun(s): _____

Sexual Orientation: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ Black/African-American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Multiracial ☐ Hawaiian Native/Pacific Islander ☐ Other

Religion: ☐ None ☐ Protestant ☐ Catholic ☐ Jewish ☐ Mormon ☐ Orthodox ☐ Muslim ☐ Hindu ☐ Buddhist ☐ Atheist/Agnostic ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Full-Time Student ☐ Part-Time Student

Occupation/Employer _____

Annual Family Income_____

Disability Status: _____

Sairalyn's Studio

www.sairalyn.com
studio@sairalyn.com

225 W 35th Street, 7th fl.
New York, NY 10001

(646) 801-4724

Emergency Contact Information

Full Name _____

Phone Number _____

Alternate Phone Number _____

Email _____

Relationship _____

Therapy History

Current reason(s) for seeking therapy: _____

_____

_____

_____

Estimate the severity of the problem for which you are seeking care:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

How many sessions or how much time do you think you might need to successfully resolve the problem? ☐ 1-10 sessions ☐ 10-20 sessions ☐ 20+ sessions ☐ ongoing, longer-term therapy

Previous experience with therapy? ☐ Yes ☐ No

If yes, when and for what issues? _____

_____

Was it helpful? (Why or why not?) _____

_____

Have you ever been hospitalized? (If yes, please provide details) _____

_____

_____

Are you currently taking any medications? (If yes, please list names, dosages, and prescribing doctor) _____

_____

_____

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (If yes, please indicate age, circumstances, and whether it led to hospitalization or legal problems). _____

_____

_____

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Please list any past/present drug and alcohol use. What have you used and how much? What are you currently using and how much? Has it ever affected your work or your relationships? _____

_____

_____

What are you main worries or fears?_____

_____

What do you consider your main strengths?_____

_____

What are your primary challenges right now?_____

_____

What are your most important hopes or dreams?_____

_____

Please add any additional information that may be helpful to our work together:

_____

_____

Relationships

Do you live with others? What is their relationship to you? _____

_____

_____

Please name your present spouce/partner(s) and describe your relationship satisfaction:

_____

_____

Are there any other current relationships that are a significant focus in your life right now?

(If yes, please describe):_____

_____

Referral Information

Who referred you to me or how did you hear of my practice?

☐ Friend ☐ Web Search ☐ Former or current client ☐ Psychology Today

☐ Other (please specify) _____

☐ Therapist or doctor referral (please specify) _____

☐ Teacher or school administrator referral (please specify) _____

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Follow Up Information

To help me continue my development as a clinician, I send a brief survey to clients 4-6 weeks after they have ended treatment with me.

Completing this form is optional and anonymous. Please choose one of the following:

☐ Please email me the link to the form. I understand tht I can decide at that time whether or not I wish to complete it.

☐ Please opt me out of receiving this form. I do not wish to receive it.

I am also interested in whether you are able to maintain yor treatment goals when you complete therapy with me. I would like to send a brief form to check n with you a year after you finish treatment.

Please choose one:

☐ You are welcome to contact me one year after I complete therapy to check in on how I am doing. I understand that I can decide at that time whether or not I wish to respond.

☐ Please opt me out of the one-year follow up.

_____

Full Name (PRINT)

_____ _____

Signature Date

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Confidential Child Intake Form

Child's First Name _____ Middle Initial_____

Last Name _____

Age_____ Date of Birth_____

Address _____

City _____ State_____

Zip _____ County _____

Name of Primary Contact _____

Relationship to Child_____

School Information

Name of School _____

Child's Grade_____

School Address_____

_____

Counselor or Teacher _____

Phone Number_____

Email _____

Parent Information

Mother's Name _____

Age_____ Date of Birth_____

Address _____

_____

Email Address _____

Primary Phone Number _____

Father's Name _____

Age_____ Date of Birth_____

Address _____

_____

Email Address _____

Primary Phone Number _____

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Other Important People *(optional)*

Name _____

Relationship to Child_____

Email Address _____

Primary Phone Number _____

Name _____

Relationship to Child_____

Email Address _____

Primary Phone Number _____

Name _____

Relationship to Child_____

Email Address _____

Primary Phone Number _____

Name _____

Relationship to Child_____

Email Address _____

Primary Phone Number _____

Name _____

Relationship to Child_____

Email Address _____

Primary Phone Number _____

Name _____

Relationship to Child_____

Email Address _____

Primary Phone Number _____

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Billing and Credit Card Authorization

Payments are due at the beginning of every session.

CASH or CHECK payors will be asked for payment before beginning the session.

CREDIT CARD payors will be charged to the card on file below unless otherwise specified.

_____I understand the Sairayn's Studio billing policy. *(Please initial)*

Receipt Information:

Will you be requesting a monthly invoice indicating that services have been paid and thus serving as a receipt? ☐ No ☐ Yes *(please select one option below)*

☐ For insurance purposed *(This option requires a diagnosis, which we will discuss)*

☐ For Flex Spending *(No diagnosis required)*

Cardholder's Information:

First Name _____ Middle Initial_____

Last Name _____

Name of client (*if different*) _____

I authorize Sairalyn's Studio and Intuit.com to charge my credit/debit card for professional services as follows:

_____Session charges, not to exceed $_____ per date of service. *(Please initial)*

_____To charge my card for the balance of fees not paid, missed appointment fees, late cancellation fees, and bad check amounts plus a bad check fee of $30 per bad check. *(Please initial)*

Type of Card: ☐ American Express ☐ Visa ☐ Mastercard ☐ Discover

Card Number_____

CVV Number _____ Expiration Date_____

Card Holder's Billing Address ***exactly*** as it appears on Credit Card Statements

Street _____

City _____ State _____ Zip_____

If I have question about these charges, I agree to contact Sairalyn's Studio at studio@sairalyn.com or (646) 801-4724. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yields a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider. This authorization is valid until I provide you with written cancellation.

Cardholder Signature_____

Date _____

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