Tamara J. Galinsky, MA, ATR-BC, LPC, LCPAT
Registered & Board Certified Art Therapist
8605 Cameron Street ~ M-4
Silver Spring, MD 20910
artxtamara@gmail.com
(202) 579-9567
www.tamaragalinsky.com

Client Intake Form

Name_____Age_____Date_____
_
Date of Birth_____Gender_____

Relationship Status: _____

How did you hear about me?:_____

	Telephone Number	May I leave a message for you at this number?
Home		Yes No
Work		Yes No
Cell		□ Voice □ Text

Mailing Address:

_____

_____

E-Mail*: _____
*Please be aware that email may not be confidential

Emergency Contact:

Name:_____Relationship_____

Phone:_____

Physical History

General Health: _____

Last medical examination_____

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Are you now under a doctor's care?_____ If yes, name of doctor_____

Reason for doctor's care_____

Please list any daily medications, including dosage, below:

_____

_____

_____

_____

Please describe any previous hospitalizations for physical or mental illness:

_____

_____

_____

_____

Any recent major illnesses or surgeries? _____

Any recurrent or chronic conditions?_____

Do you smoke? _____ Do you take recreational drugs? _____

If yes, what kind? _____

Do you drink? _____ If yes, how much? _____

Please describe dates and duration of any previous therapy/counseling:

_____

Work History

Occupation_____ How long?_____

Hobbies/Avocations_____

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Present Situation

Briefly describe why you decided to come for counseling/therapy

Briefly describe what you would like to work on in therapy

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Personal Agreements

I understand that I may be asked to do certain "homework exercises" such as reading, activities, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

I further understand that the majority of the work done will be to resolve issues and will depend on my honesty and willingness to do the things I need to do to move forward, even if it is painful and difficult.

I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent, unless I am violating codes of abuse of children or elders and/or harm to myself or others.

I understand that payment in the form of cash or check is due at the beginning of each session hour and that I will pay in full for appointments not canceled with 24 hours notice. Exceptions will be made in the case of emergencies or inclement weather.

If financial hardships arise during the course of therapy, it is my responsibility to request a sliding scale. It is important to my therapist that therapy not be discontinued due to solely financial reasons, so sliding scale options or less frequent appointments will be available.

My therapist will make bills available that can be submitted to insurance for reimbursement should I wish to work through my insurance. My therapist does not accept insurance at this time.

Freedom to withdraw: I have the right to end therapy at any time. If I wish, my therapist will give me the names of other qualified psychotherapists.

It is recommended that I let the therapist know when I am ready to leave therapy. It is advisable to discuss this in the context of a therapy appointment so that proper closure can be had by all parties.

_____

(Client signature and date)