

Radiant Living Life Management Contact Data

Linda H. Streeter, MA

Registered Marriage & Family Therapist Intern

Please complete form and fax to 407.339.1116 or email to lstreeter@radiantlifemgmt.com

Name:		Gender:	Age:	Referred by:	
Phone #1: Home <input type="checkbox"/> Cell <input type="checkbox"/> work <input type="checkbox"/>		Ok to call and identify? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Phone #1: Home <input type="checkbox"/> Cell <input type="checkbox"/> work <input type="checkbox"/>		Ok to call and identify? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:		OK to identify <input type="checkbox"/> Yes <input type="checkbox"/> No		OK to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mailing Address:		City:		State: FL	Zip:
Ethnicity:		High School <input type="checkbox"/> Yes <input type="checkbox"/> No		Yrs of college:	Date of Birth:
Are You a Florida Resident <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have mental health benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No;
Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Do you have children? Names/Ages				Who is counseling for? <input type="checkbox"/> Self <input type="checkbox"/> Couple <input type="checkbox"/> Children <input type="checkbox"/> Family
Spouse/Partner's name:		Monthly Income:		No. of family members:	
<i>We use the following information to determine how to best meet your needs. Please be <u>specific</u>.</i>					

What do you want to see a counselor about?

How does this problem impact your life functioning? (Check One)

Not At All A little bit Moderately Quite a bit extremely

In the last two weeks, have you been afraid you might hurt yourself or someone else? Yes No

Has a friend or family member ever committed suicide? Yes No

If yes, please describe the person's relationship to you: _____

Please indicate specific times you are available for an appointment:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Any time AM/PM	After AM/PM	Any time AM/PM	After AM/PM	After AM/PM	Any time AM/PM

Below To be completed by Staff

Is client sliding fee schedule applied? Yes No, regular rate of \$150 applied

If yes, amount per visit: \$ _____	Based upon monthly Income of \$ _____	And family size of: _____
Patient understands in addition to the reduced rate of \$ _____ an additional \$75 for intake/assessment is due for a total of \$ _____, at the first session only. Additional sessions are at established reduced rate		
Intake counselor's name: _____		