GENERAL INFORMATION FORM

Date:	Last Name:	First Name:	Middle:	
Date of Birth:	Age:	Address:		
Apt Number:	City:	State:	County:	Zip:

Contact Phone: _______________
___ Cell ___ Work ___ Home
___ OK to call ___OK leave VM
___ OK to text

In Case of Emergency, Call:
____

Relationship:_________________

Referred By:
___ JanGallagher.com
___ Google
___ PsychologyToday.com
___ Friend
___ Family
___ EAP
___ Other _________

Employer:___________________

___ Part Time ___ Full Time
___ Retired ___ Disability
___Unemployed

Occupation: _________________
Educational Background:
____

Relationship Status: ___ Single ___ Live Together ___ Engaged ___ Married ___ Partners ___ Separated
___Divorced ___ Alternative Lifestyle

Partner/Spouse Name: ___________________ Age: ___ Occupation: _________________Phone: _________

Gender: ___ Male ___ Female ___ Transgender (Male) ___ Transgender (Female)

Optional Identification: LGBTQ+ ___ Yes ___ No Pronouns Preferred: __________________________

Children Name/Age:
__________/ _____
__________/ _____
__________/ _____
__________/ _____

Step Children Name/Age
__________/ _____
__________/ _____
__________/ _____
__________/ _____

Religious Preference:
____

Spiritual Preference:
____

Previous Counseling?
Yes ___ No ___

If yes, ____ Individual
____Couples, ____ Family,
____Group, ____ IOP,
____ In Patient

Primary Parents Names/Ages:
Father: _____________/ _____
Mother: ____________/ _____
Divorced? Yes____ No ____
Additional Parents Names:
____________, _____________

Brothers & Sisters Names/Ages:
__________ /____
__________/____
__________/____
__________/____

Any Family History Of:
____ Anxiety
____ Depression
____ Alcohol Drug Addiction
____ Suicide Attempt

I would like more information about the services checked: ____ Integrated Mind/Body Approach
____Brain Health Assessment ____Nutritional/Diet Information ____ Energy Psychology Methods

GENERAL INFORMATION FORM

Check below if these concerns apply to you either in the past and/or the present:

	PAST	CURRENT
Alcohol Abuse		
Addiction		
Anger		
Anxiety		
Appetite Changes		
Abuse or Assault		
Blackouts		
Crying spells		
Depression		
Difficulty Concentrating		
Drug Abuse		
Eating Disorder		
Fears		
Grief		
Hallucinations		
HIV/AIDS Concerns		
Homicidal Thoughts		
Hopelessness		
Identity Issues		
Impulsivity		
Lack of Motivation		
Learning Problems		
Low Energy		
Memory Problems		
Mood Swings		
Obsessive Thoughts		
Panic Attacks		
Self Harm		
Sexual Abuse or Assault		
Sleep Difficulties		
Suicidal Thoughts		
Suicidal Attempts		

Are you currently taking any mental health medications? ____Yes ____ No If yes, name of medication(s):____________________________________. Are they helpful? ____Yes ____ No

Current Physical Health Concerns:____

Current Physical Health Medication Names: ____

Past Physical Health Problems and/or Major Surgery: _______________________________________

Physicians: ____

Name/Specialty Name/Specialty Name/Specialty

Jan Gallagher, LMHC