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) ___ Non-Binary

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

Children Name/Age:	Step Children Name/Age	Religious Preference:	Previous Counseling?
_____/ _____ _____/ _____ _____/ _____ _____/ _____	_____/ _____ _____/ _____ _____/ _____ _____/ _____	_____ Spiritual Preference: _____	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: _____

Past Physical Health Problems and/or Major Surgery: _____

Treating Physicians: _____

Name/Specialty Name/Specialty