John Gallagher, LMHC
Adult Intake

1. Name:______________________________

Address:______________________________

City, State, Zip_________________________

2. Telephone:

(H)______________________________

(C)______________________________

(W)______________________________

e-mail___________________________

3. I may be contacted :
   - At Home ☐ Yes ☐ No
   - At Work ☐ Yes ☐ No
   - Via cell ☐ Yes ☐ No
   - Via e-mail ☐ Yes ☐ No

4. Gender: ☐ Male ☐ Female

5. Date of Birth: __________ Age _______

6. Medical Insurance Carrier:

____

7. Race:

____

8. Last Grade Completed:

____

9. Employer:

____

10. Job Title:

____

11. Employment Status: ☐ Part-time ☐ Full-time

12. Length of time employed in present position:________

13. Job Satisfaction:

☐ Satisfied ☐ Neutral ☐ Dissatisfied

14. How did you hear about this office?

☐Brochure	☐ Co-worker
☐Letter	☐ Family Member
☐HR Personnel	☐ Former Client
☐Dr/Medical	☐ Business Card
☐News Paper	☐ Insurance
☐Presentation	☐ Newsletter

☐Other _________________________

15. Please describe the primary issues which bring you here today:

____

____

____

16. Have these issues intensified? If so, explain?

____

____

____

17. Have you experienced any major life changes in the past year?

☐ No ☐ Yes (explain):

____

____

____

Relationship Status:

☐ Single		
☐ In Relationship	___ YRS	___ MTHS
☐ Married	___YRS	___ MTHS
☐ Separated	___ YRS	___ MTHS
☐ Divorced	___ YRS	___ MTHS
☐ Widowed	___ YRS	___ MTHS

18. Name of significant other:

____

19. Significant other's occupation: ____________

20. Significant other's age: _____ sex: _____

21. Race: ______________________

22. Name(s) of Children: Age: Sex:

____

____

____

____

____

23. Prior to this visit, have you ever seen a counselor, psychologist, or psychiatrist before?

☐ No ☐ Yes

If yes, please explain and include provider names:

____

____

____

____

24. Length of Treatment:__________

25. How long since last session? ___________

26. Please list any prescribed medications that you have taken in the past for psychological issue:

____

____

27. Have you ever been hospitalized for psychiatric issues?

☐ No ☐ Yes (If yes, please explain)

____

____

28. Have you been treated for alcohol or substance issues? ☐ No ☐ Yes (If yes, please explain):

____

____

29. Have you ever been the victim of physical or sexual assault (rape, incest, sexual abuse)?
☐ No ☐ Yes

30. If yes, did you receive treatment? ☐ No ☐ Yes

31. What is the name and phone number of your family doctor?

____

32. Please list all any medical conditions:

____

____

____

____

33. Are you currently taking any medication(s) (prescription or nonprescription) on a regular basis?
☐ No ☐Yes (If yes, specify)

____

____

____

____

____

(Please attach additional sheet if needed)

34. Indicate all mood/mind-altering substances you're using or have used within the past year:

Type of Substances / Frequency / Quantity

____

____

____

____

35. Have there been any changes in your health in the past year? ☐ No ☐ Yes (SPECIFY BELOW):

____

____

45. Please list any accidents and/or hospitalizations:

____

____

46. Please indicate if you have a history of head trauma, seizure, or any other neurological condition:

____

____

47. Have you ever attempted or considered suicide?
☐ No ☐Yes

48. Have you ever been arrested? ☐ No ☐Yes

49. Have you ever been in trouble for threatening or harming others? ☐ No ☐Yes

50. Are you currently having any legal trouble?
☐ No ☐Yes (If yes, please explain)

____

____

51. If applicable, what is your religious faith?

____

52. Do you have any spiritual or religious practices that bring you comfort? ☐ No ☐Yes
    If yes, explain ________________________

53. Who do you turn to when you need support?
    ____
    ____

54. List mental health or substance/alcohol issues of family members:
    Relationship: Issue:
    ____
    ____
    ____

55. Is there presently any violence or abuse in your home?
    ☐ No ☐Yes

EMERGENCY CONTACT:

Name:_____________________________________

Phone:_____________________________________

Relation to client:____________________________

LIFESTYLE QUESTIONS:

How many hours do you sleep each night? ________

Have you had any recent changes in sleep patterns?
☐ No ☐Yes (if yes please explain)
____
____

Has fatigue been a problem lately? ☐ No ☐Yes

How many meals do you eat each day?__________

Have you had any recent changes in weight or appetite?
☐ No ☐Yes (if yes please explain)
____
____

Do you drink caffeinated beverages? ________

If applicable, how many caffeinated beverages do you consume each day? ________ What types? ________

Do you use Tobacco? ☐ No ☐Yes

If applicable, how many cigarettes do you smoke each day? _______

Do you exercise regularly? ☐ No ☐Yes

If applicable, how often do you exercise?_________

Do you drink alcohol? ☐ No ☐Yes

If applicable, how many drinks per week? _________

List interests or hobbies:
____
____
____
____

Have you been enjoying these interests or hobbies lately?
☐ No ☐Yes (If no, please explain)
____
____
____

Do you receive a medical check up each year? ☐ No ☐Yes

When did you last see your family doctor and for what reason? ____________________________________
____

PLEASE CHECK ONE:

____ I authorize John Gallagher, LMHC to thank the person who referred me.

_____ ***I do not*** authorize John Gallagher, LMHC to thank the person who referred me.

If authorization is granted, please give the name and phone number of the person who referred you:

Name: Phone:

I would like John Gallagher, LMHC to send me informational emails at the address indicated on page one of this form.
Yes___ No___

Signature: ___________________________

Date: ______________________________