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: _____