LJ GALLAGHER PSYD & ASSOCIATES, PLLC

CLIENT INFORMATION

DATE: _____

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Parent's Names (if client is a minor): _____

Cell Phone: _____ May we leave a message? Yes/No
Home Phone: _____ May we leave a message? Yes/No

Email: _____ May we email you? Yes/No
**Please note: Email communication is not considered to be a confidential medium of communication.*

Who referred you to our services: _____

Present Relationship Status (please circle):
Never Married Married Domestic Partnership Divorced Separated Widowed

Please list children and their ages: _____

In case of emergency, who do we have permission to contact:

Name: _____ Phone: _____ Relationship: _____

MEDICAL/HEALTH INFORMATION

Family Physician: _____Physician Phone: _____
**May we contact your family physician to simply notify them that we will be providing psychological care? Yes/No*

How would you rate your current physical health: *Very Good Good Satisfactory Unsatisfactory Poor*

Please list any allergies you have (food, medication, etc): _____

Health problems you are currently experiencing: _____

Please list history of major surgeries or serious injuries: _____

Please list any medications you are currently taking: _____

Please describe any chronic pain you are experiencing: _____

Please describe any problems you are experiencing with your appetite/eating habits: _____

Please describe any sleep problems you are experiencing: _____

MENTAL HEALTH INFORMATION

Have you participated in counseling previously: Yes / No When: _____ Where: _____

What brings you to counseling currently: _____

What would you most like to accomplish out of your time in therapy: _____

What significant life changes or stressful events have you experienced recently: _____

_____

Are you experiencing overwhelming sadness, grief or depression: Yes/No How long: _____

Are you experiencing anxiety, panic attacks, or phobias: Yes/No When did this start: _____

Please describe any substance use such as alcohol, tobacco, marijuana, etc (type, frequency, amount):

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

Alcohol/Substance Use	Yes/No	_____
Anxiety	Yes/No	_____
Depression	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obsessive Compulsive Behavior	Yes/No	_____
Bipolar Disorder	Yes/No	_____
Suicide Attempts	Yes/No	_____

GENERAL INFORMATION

What are some of your hobbies/interests: _____

Please describe your current employment and/or school information (occupation, satisfaction, concerns):

_____

Please describe any concerns you have about your close relationships: _____

_____

Please describe your spiritual or religious beliefs (if applicable): _____

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INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Insurance ID #: _____ Insurance ID #: _____

Group #: _____ Phone #: _____ Group #: _____ Phone #: _____

Policy Holder Name: _____ Policy Holder Name: _____

Date of Birth: _____ Phone #:_____ Date of Birth: _____ Phone #: _____

Relationship to Insured: _____ Relationship to Insured: _____

I authorize and request my insurance company to make payments directly to L.J. Gallagher, Psy.D. & Associates, PLLC. I also authorize L.J. Gallagher, Psy.D. & Associates, PLLC or any billing agent acting in their behalf, to release any information necessary to process any claim on my behalf. I understand I am responsible for all charges regardless of insurance coverage.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. Full payment is due at the time of service. Co-pays must be paid on the date of service unless otherwise arranged with your therapist.

It is important to attend therapy on a regular basis for the most effective treatment. We understand that extenuating circumstances, such as illness or unexpected events, can occur. Whenever possible, please notify us 24 hours in advance if your scheduled appointment needs to be cancelled. **There will be a $50 fee for appointments missed or cancelled without 24 hour advanced notification, unless you and the therapist agree otherwise.**

We request a credit card number be stored in the file, to be billed for balances not paid within 30 days for missed/late appointment fees, deductibles and/or copays. Please complete information below. By signing you consent to these polices. Please talk with your therapist to make other arrangments.

Credit Card #: _____3 digit code: _____ Exp. Date: _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____