Jeremy Gallas, Psy.D.
Licensed Psychologist #PY0790

New Client Questionnaire

CONTACT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

Preferred Phone Number: _____ Type: Home Cell Work Other

May Dr. Gallas leave messages?: YES NO

Email: _____

May Dr. Gallas send email regarding scheduling?: YES NO

DEMOGRAPHIC INFORMATION (Please answer to the extent you are comfortable.)

Ethnicity: _____ Place of Birth: _____

Sexual Orientation: _____ Gender: _____

Are you a parent? YES NO Do you currently have a diagnosed disability? YES NO

PRESENTING CONCERN(S)

Referred by: _____

Primary reason(s) you are seeking services:

_____

_____

_____

_____

Are you experiencing any of the following? Check all that apply.

____ Sadness or Depression ____ General Anxiety

____ Panic Attacks ____ Specific Fears/Phobias _____

____ Obsessive Thinking ____ Relationship Concerns ____ Sexual Issues

____ Disordered Eating and/or Body Image Concerns____ Grief and/or Recent Loss

____ History of Abuse (emotional, physical, sexual) ____ Anger Problems

____ Recent Sexual Assault ____ Family Problems ____ Loss of Energy

____ Self Harm Behaviors (w/o Suicidal Intent) ____ Sleep Problems

____ Problems with Attention or Concentration ____ Academic Problems

____ Test Anxiety ____ Problems Making or Keeping Friends ____ Substance/Alcohol Abuse

Other Symptoms Not Listed Above:

_____

_____

_____

Are you currently experiencing suicidal thoughts? YES NO

Have you ever purposefully injured yourself **without** suicidal intent? YES NO

Have you ever made a suicide attempt? YES NO

If yes, when?: _____

Are you currently having thoughts about harming someone? YES NO

CURRENT/ PAST MENTAL HEALTH TREATMENT

Are you currently in counseling or therapy elsewhere?: YES NO

If yes, please list the name of your current service provider:

_____

_____

Have you had counseling/ psychotherapy in the past? YES NO

If yes, please include the provider, approx. dates, and any diagnoses:

_____

_____

_____

_____

Are you **currently** taking prescribed **psychiatric** medications? YES NO

If yes, please specify which medication(s):

_____

_____

Have you taken **psychiatric** medicine in the **past**? YES NO

If yes, which medication and when?:

_____

_____

Have you ever been psychiatrically hospitalized? YES NO

If yes, when, where, and for what?

_____

_____

Have you ever been tested for ADHD or Learning Disabilities? YES NO

If yes, please include the provider, approx. dates, and any diagnoses:

_____

_____

FAMILY INFORMATION

Relationship status (check which applies): Who currently resides in your home (Name, relationship, age)?:

____ Single _____

____ Living with partner_____

____ Married/partnered _____

____ Separated_____

____ Divorced _____

____ Widowed_____

____ Other _____

Has anyone in your family had a psychological disorder or diagnosed disability? Please share whom and the disorder/disability:

_____

_____

_____

_____

GENERAL HEALTH

Are you currently receiving care for a medical condition(s)? YES NO

If yes, what condition and name your provider:

_____

_____

Rate your present physical health: Poor Fair Good Excellent

When was your last physical exam? _____

Pills, vitamins, and supplements:

_____

_____

Do you exercise? YES NO

If yes, # times/ frequency: _____

Do you drink caffeinated beverages? YES NO

If yes, # drinks/frequency: _____

Do you drink alcohol? YES NO

If yes, # drinks/frequency: _____

Do you use drugs/ substances? YES NO

If yes, specify which drug and frequency:

_____

_____

Do you consider your substance or alcohol use to be a problem? YES NO NOT SURE

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Dr. Jeremy Gallas and associates to use unsecured email to transmit to me the following protected health information:

Information related to the scheduling of meetings or other appointments

I have been informed of the risks of transmitting my protected health information by unsecured means, including but not limited to my confidentiality in treatment. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____
Signature Date

INFORMED CONSENT SIGNATURE PAGE
**If you do not sign this form we cannot provide psychological services to you.*

I have read, or have had read to me, the information and expectations outlined in:

1) Informed Consent – Information, Services, and Payment
2) Electronic Communication Policy

I have discussed the points I did not understand and have had my questions fully answered.

I agree to act according to the information and expectations and terms covered in these documents. I agree to enter into therapy with Dr. Jeremy Gallas and associates, and to cooperate fully and to the best of my ability, as shown by my signature below.

Client's Name: _____
(please print)

Client's Signature: _____ Date _____