From the Office of
Tracy Fox Galluppi, LCSW, LLC 732-991-3809

Name:____ Date:______________________
Address____
____
Home phone:__________________________________ May I leave a message__________________
Cell ____ May I leave a message__________________
Work phone:___________________________________ May I leave a message__________________
SS#:_________________________________ Age:_______________ Date of birth:_________________

How did you hear about me:____
May I thank this person for the referral?________________

Religious/Spiritual affiliation:____
Are you practicing?__________________
Ethnic and racial background____

Primary Physician____
PP address ____
PP phone # ____
May I tell your doctor that you have entered into therapy with me: Yes No

Emergency Contact Name_____________________________________ Relationship_____________
Address____
Phone #s____

Employer:__________________________________ Your Job Title_____________________________

Significant Relationship/Partnership/Marriage: Single, Married, Partnered, Divorced, Separated, Widowed

Do you have children? How many and their ages _-
____

Members of Household (Please list name, age, relation to you)
____
____
____
____
____
____

Level of education:____
Military?____

Why are you seeking treatment now?

Have you ever received mental health services before? Yes No

When	With whom	For what	results

Have you ever taken medication for psychiatric or emotional problems?

when	Prescribed by	Medication	For what	What results

Name of current psychiatrist____
Address of psychiatrist____
Phone # of psychiatrist____

What else should I know about you?