

# Molly Carr, AMFT



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## **Psychotherapy Client Intake Form**

*Please provide the following information and bring it with you to your first appointment. Leave blank any answers you do not feel comfortable answering. The information you provide on this form is confidential and will not be shared without your consent. If there is any other information that you would like me to know, please feel free to write it on the last page.*

### **PERSONAL INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Name of Parent/Guardian (if under 18): \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Email: \_\_\_\_\_

Phone (check preferred): c Mobile: \_\_\_\_\_ c Home: \_\_\_\_\_

May I leave a voicemail message?  Yes  No  Only on preferred phone number

May I send a text message?  Yes  No  Only on preferred phone number

Mailing Address: \_\_\_\_\_

### **MENTAL AND PHYSICAL HEALTH**

1. How would you rate your current **physical** health?

Poor  Fair  Good  Excellent

Comments: \_\_\_\_\_

2. Are you currently experiencing specific health issues?  No  Yes

If yes, please describe: \_\_\_\_\_

3. How would you rate your current sleeping habits?

Poor  Fair  Good  Excellent

4. Are you currently experiencing any sleep problems?  No  Yes  
If yes, please describe: \_\_\_\_\_

5. How many times per week do you exercise? \_\_\_\_\_ What types of exercise do you engage in?  
\_\_\_\_\_

6. Are you currently experiencing eating or appetite problems?  No  Yes  
If yes, please describe: \_\_\_\_\_

7. Are you currently experiencing overwhelming grief or depression?  No  Yes  
If yes, please describe: \_\_\_\_\_

8. Are you currently experiencing anxiety, panic attacks, or phobias?  No  Yes  
If yes, please describe: \_\_\_\_\_

9. Are you currently experiencing any chronic pain?  No  Yes  
If yes, please describe: \_\_\_\_\_

10. Are you currently taking any psychiatric medications?  No  Yes  
If yes, which ones and what dosage? \_\_\_\_\_

11. Have you ever experienced any of the following? (Please indicate with a \* which ones you are currently experiencing.)

Anxiety .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Depression.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Self-harming behaviors .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Drug and/or alcohol abuse.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hallucinations.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Eating disorder.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Body image problems .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Repetitive thoughts (e.g., obsessions) .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Repetitive behaviors (e.g. compulsions) .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Panic attacks.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Unexplained losses of time .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mood swings .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mania .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes

12. Have you experienced any recent life changes or major events that are having an impact on your physical or mental health?  No  Yes If yes, please describe: \_\_\_\_\_

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#### LIFESTYLE & EMPLOYMENT

13. Please describe your current average alcohol intake:  
 I don't drink alcohol **OR** I drink about \_\_\_\_\_ drinks per  day  week  month

14. How often do you use recreational drugs?  
 Never  Infrequently  Monthly  Weekly  Daily  
If yes, please describe: \_\_\_\_\_

15. How would you describe your romantic status?  
 Single  In a relationship  Married  Separated  Divorced  Widowed

16. If you are currently in a relationship, for how long? \_\_\_\_\_

17. If you are currently in a relationship, how would you describe the quality of your relationship?  
\_\_\_\_\_

18. Do you have any children?  No  Yes  
If yes, how many and what ages? \_\_\_\_\_  
Do they live with you?  No  Yes  Other (specify): \_\_\_\_\_

19. Are you currently employed?  No  Yes  
If yes, what is your occupation? \_\_\_\_\_

20. If you are currently employed, how satisfied are you with your work?  
 Very unsatisfied  Unsatisfied  Neutral  Somewhat satisfied  Very satisfied

21. If you are currently employed, how stressful is your job?  
 Very stressful  Stressful  Neutral  Not very stressful  No stress

22. Do you consider yourself to be a religious or spiritual person?  No  Yes

If yes, please describe: \_\_\_\_\_

23. Have you ever been in therapy before?  No  Yes

If yes, with who and when? \_\_\_\_\_

24. What would you like to accomplish in therapy? \_\_\_\_\_

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#### **FAMILY MENTAL HEALTH HISTORY**

Please identify any family mental health history of which you are aware. If you respond yes, please identify the relationship of that family member to you (e.g., father, sister, etc.)

#### **Relationship**

Alcohol / Substance Abuse .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Anxiety.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Depression .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Domestic Abuse .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Eating Disorders .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Obesity .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Obsessive Compulsive Behavior.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Schizophrenia.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Suicide Attempts .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

#### **ADDITIONAL INFORMATION**

If there is any other information you would like to share, please feel free to include it here:

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