

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: _____

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? _____

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:

