
MOLLY MILGROM PSYCHOTHERAPY

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Client Intake Form

Please answer the following questions as completely as possible. Information is strictly confidential.

Today's Date: _____

Full Name: _____

Address: _____

Phone: _____ Alt. Phone: _____ May I leave a message? ☐ Yes ☐ No

Email (OPTIONAL): _____ May I email you? ☐ Yes ☐ No
**Please note: Email correspondence is not considered to be a confidential medium of communication and use should be limited to communication for administrative matters only such as scheduling appointments.*

Ethnicity: _____ Preferred Pronouns: _____

Date of Birth: _____ Birthplace: _____

Employer: _____ Position: _____

Spouse/Partner (Name, Age): _____

Children (Name, Age): _____

_____

Have you seen a psychotherapist before? ☐ Yes ☐ No If yes, when? _____

Name of previous therapist(s): _____

_____

Please list any current medications, dosages you are taking, and the prescriber names:

_____

_____

Date of last medical exam: _____

Please list any medical conditions: _____

Do you identify with any religion or spiritual group? _____

Please give a brief description of the issues you want to address:

_____

_____

_____

_____

_____

_____

Please check all of the following that concern or pertain to you

- ☐ Sadness
- ☐ Crying
- ☐ Fatigue/low energy
- ☐ Poor concentration
- ☐ Guilt
- ☐ Appetite changes
- ☐ Hopelessness
- ☐ Sleep issues
- ☐ Loneliness
- ☐ Lost interest in sex
- ☐ Perfectionism
- ☐ Memory problems
- ☐ Academic/Career Issues
- ☐ Relationship Issues
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Shortness of breath
- ☐ Fear or worry
- ☐ Nightmares
- ☐ Flashbacks
- ☐ Confusion
- ☐ Hyperactivity
- ☐ Physical Pain
- ☐ Low self esteem
- ☐ Mood Swings
- ☐ Impulsiveness
- ☐ Grief/loss
- ☐ Coping with medical issue
- ☐ Body Image/Eating Concerns
- ☐ Self-injury
- ☐ Anger/Irritability
- ☐ Aggression
- ☐ Alcohol/Drug Use
- ☐ Abuse/Sexual Assault
- ☐ Hearing/seeing things that others do not

Please use this space below to tell me more about any of the items that you checked above:

_____

_____

_____

_____

_____

Please tell me the goals you envision for our work together:

_____

_____

_____

_____

Please give a brief description of your childhood:

_____

_____

_____

_____

_____

_____

Please tell me about your family and significant relationships:

_____

_____

_____

_____

Please add any information you feel may be useful in our work together:

_____

_____

_____

_____

Please tell me how you heard about my practice: _____

If someone referred you, do I have your permission to call to thank him or her? ☐ Yes ☐ No

Emergency Contact (Name, Relationship, Phone): _____

_____

Thank you for your completing this questionnaire.