
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

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

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.