



Dr. Leah Farrell-Carnahan, PhD
Licensed Clinical Psychologist
Atlanta CBT, LLC
118 East Maple Street
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(404) 710-6605

Please take some time to work with your parent or guardian to complete this form to provide me some information about yourself and your reasons for seeking therapy services. Please bring this completed form to your intake appointment. I will likely ask you to complete additional questionnaires about specific problems you are experiencing. Taken together, in addition to the information you provide me in your intake appointment, this information will inform whether or not we are a good treatment match and if so, the elements we will include in your tailored treatment plan.

Today's Date: _____

CONTACT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Age: ____ Gender: ____

Complete Address:

Home phone: _____ Cell phone: _____

May I call and leave a message on all numbers listed above? Yes No

Legal Guardian:

Name: _____ Phone: _____ Is this a parent? Yes No

Relation: _____

Emergency Contact:

Name: _____ Phone: _____ Relation: _____



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What school do you go to? _____ Grade?: _____

What, if any school-related concerns do you have?

Do you have a job?: Yes No Employer: _____

How did you learn about Atlanta CBT, LLC?

If a person referred you, may I thank them? Yes I'd prefer not

REASONS FOR SEEKING SERVICES

Please describe in a few sentences your main reasons for seeking services

Please check all of the following items that are concerns at this time:

- _____ Abuse (emotional, physical, verbal, sexual, neglect)
- _____ Academic or work issues
- _____ Aggression/violent behavior
- _____ Alcohol or drug use
- _____ Anxiety, nervousness
- _____ Body image
- _____ School or career concerns, choices
- _____ Compulsive behaviors
- _____ Concentration, Decision making, indecision
- _____ Grief issues
- _____ Depression, sadness, crying



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- _____ Parents' divorce, separation
- _____ Eating problems
- _____ Family relationships
- _____ Fears, phobias
- _____ Financial problems
- _____ Gambling
- _____ Guilt
- _____ Health, medical concerns
- _____ Hallucinations
- _____ Identity issues
- _____ Legal problems
- _____ Loneliness, withdrawal, or isolation
- _____ Mood swings
- _____ Motivation issues
- _____ Panic attack
- _____ Pregnancy related concerns
- _____ Repeated troubling thoughts
- _____ Relationship concerns
- _____ Self-injury, mutilation
- _____ Self-neglect, poor self-care
- _____ Sexual assault
- _____ Sexual concerns
- _____ Sexual orientation/identity
- _____ Gender
- _____ Sleep problems
- _____ Stress
- _____ Suicidal thoughts
- _____ Violent thoughts
- _____ Other, please describe:



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PREVIOUS PSYCHOLOGICAL TREATMENT

Please list all past psychological treatment, including any hospitalizations. Please include reasons, location, and timeframe.

Name and number of provider who is currently prescribing you any medications for your mood or mental health symptoms, if applicable:

Please list any current psychiatric medications (with dosages) you are taking and reason they are prescribed:

Psychiatric medications taken in the past, if applicable:

How do you typically cope with challenges / stress?



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What are your strengths?

What are your hobbies and what do you like to do for fun?

How do you feel about coming to therapy?

What do you want to make sure I know?

What are the main things that would be different in your life if therapy is helpful?

MEDICAL HISTORY

Please list any significant medical history (e.g., chronic conditions, accidents, major illnesses, surgeries):



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Please list any current medical problems:

Other current medications:

Name of Primary Care Provider: _____

Phone Number: _____

FAMILY MEDICAL AND PSYCHIATRIC HISTORY

Are there any medical problems in family (parents, siblings, etc.)?

yes no unsure

If yes, please list: _____

Are there any emotional/psychiatric problems in family (parents, siblings, etc.)?

yes no unsure

If yes please list: _____

Familial history of suicide attempt or psychiatric hospitalization?

yes no unsure

If yes please list: _____

History of alcohol/drug misuse in family?

yes no unsure

If yes, please list: _____



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FINANCIAL INFORMATION

_____ Name of Person Responsible for Account

_____ Street Address

_____ Home Phone

_____ Relationship to you

_____ City State Zip

_____ Work Phone

Do you have health insurance: _____ If so, name of insurance provider:
