Julie Davis, PhD

Licensed Clinical Psychologist
(716) 939-1438

Patient Name_____ DOB_____

Intake Information

In order to maximize the amount of time we are able to spend together in the first few sessions addressing your concerns, please complete the following questionnaire and bring it with you to the first session. A number of the questions and areas may not be applicable or clinically relevant to your care, in which case you can feel free to write "N/A" and move on to the next section. Please include all relevant details. The more information I have, the more helpful I can be to you. If you are unsure or uncomfortable answering any portion, please feel free to leave it blank and I will clarify any questions when we meet.

	YOUR INFORMATION		
Name			
Date of Birth			
Race/Ethnicity			
Gender			
Address			
Cell phone			
Home phone			
Work phone			
Highest degree completed	High School/ GED/ Some college/ Associate's Degree/ Bachelor's Degree/ Master's Degree/ Doctoral Degree/ Other:		
Occupation/Employer			
Marital/Relationship Status			
Emergency Contact 1	Name:	Relationship:	Phone:
Emergency Contact 2	Name:	Relationship:	Phone:

Please star (*) any phone numbers above at which I can leave a detailed voicemail message (indicating my name, detailed reasons for calling, etc.).

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With whom do you live?

Name Age Relationship

_____

_____

_____

_____

List any children not living at home:

Name Age Address (City and State)

_____

_____

_____

_____

Parents (including step-parents) and siblings:

Name Age (Year if Deceased) Address (City and State)

_____

_____

_____

_____

_____

What is your primary reason for coming to therapy:

_____

_____

_____

_____

_____

_____

_____

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Have you been to therapy in the past: ☐No ☐ Yes If yes, please complete past provider information below:

PAST PROVIDER INFORMATION			
Name of Provider	Dates received treatment	Diagnosis	Reason for leaving

Do you have a personal history and/or family history of the following conditions? Please consider yourself as well as biological relatives.

	Please write relevant names (if applicable) for each condition:
Anxiety	
Depression	
ADHD	
Behavior problems	
Learning difficulties	
Autism Spectrum Disorder	
Obsessions/Compulsions	
Bipolar Disorder	
Schizophrenia	
Problems with alcohol	
Problems with drugs	
Violent behavior	
Other:	

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Primary care physician_____ Phone #_____

Current prescription medications:

Name Dosage Started Taking Prescribed By Purpose

_____

_____

_____

_____

Over the counter medications/vitamins/supplements:

Name Dosage Started taking Purpose

_____

_____

Amt/Frequency of alcohol use: #drinks/day_____

#drinks/week_____

Caffeine intake (daily amount)_____Tobacco use (amt/frequency)_____

Other drugs (names and frequency of use)

_____

_____

Adverse reactions to medications or other substances_____

_____

Date of most recent physical exam_____

Illnesses requiring medical/surgical treatment in the past year_____

_____

Medical specialists involved in your care (please list):

_____

_____

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Do you have a history of suicide attempts? ☐No ☐ Yes

Have you ever intentionally harmed yourself (i.e., burning or cutting)? ☐No ☐ Yes

Are you currently having thoughts of suicide? ☐No ☐ Yes

Have you ever been hospitalized for psychiatric reasons? ☐No ☐ Yes

Has anyone in your immediate or extended family attempted suicide? ☐No ☐ Yes

Has anyone in your immediate or extended family committed suicide? ☐No ☐ Yes

Do you have access to guns or other weapons? ☐No ☐ Yes

Are you currently abusing any type of substance (illegal drugs, alcohol, prescription)? ☐No ☐ Yes

Do you have a history of sexual abuse? ☐No ☐ Yes

Have you experienced domestic violence? ☐No ☐ Yes

Are you currently experiencing domestic violence? ☐No ☐ Yes

Do you have a history of involvement with the legal system? ☐No ☐ Yes

Is there a family history of, or current involvement with, Child Protective Services (CPS)? ☐No ☐ Yes

Are there any pending court cases for your family? ☐No ☐ Yes

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Please read and sign:

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Davis responsible for any errors or omissions that I have made in the completion of this form.

_____
Signature of Client

_____
Date

_____
Reviewed by Dr. Davis