Julie Davis, PhD

Licensed Psychologist
(716) 939-1438

Child's 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 about your child, 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 child's 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 your child.

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.

	CHILD'S INFORMATION
Name	
Date of Birth	
Race/Ethnicity	
Gender	
Address	

	PARENT/GAURDIAN INFORMATION
Parent/Guardian 1 Name and DOB	
Parent/Guardian 1 Address	
Parent/Guardian 1 Phone Number(s)	
Parent/guardian 1 Highest Degree completed	High School/ GED/ Some college/ Associate's Degree/ Bachelor's Degree/ Master's Degree/ Doctoral Degree/ Other:
Parent/guardian 1 Occupation	
Parent/Guardian 2 Name and DOB	
Parent/Guardian 2 Address	
Parent/Guardian 2 Phone Number(s)	
Parent/guardian 2 Highest Degree completed	High School/ GED/ Some college/ Associate's Degree/ Bachelor's Degree/ Master's Degree/ Doctoral Degree/ Other:
Parent/guardian 2 Occupation	

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Is your child adopted ☐No ☐ Yes
If yes, date of adoption _____

Parent/guardian marital status: Single Married Cohabitating Separated Divorced Other

If applicable, please describe the current custody arrangement for your child (and attach copy of custody agreement): _____
_____
_____

SIBLING INFORMATION			
Name	Age/DOB	Gender	Full/Half/Step

What is your primary reason for bringing your child to therapy:
_____
_____
_____
_____
_____

Has your child been in 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

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CHILD'S CURRENT MEDICATION INFORMATION			
Name/dosage of medication	Prescribing provider	Reason/Diagnosis	Approx date started

Describe any history of medical issues:

_____

_____

_____

	FAMILY PSYCHIATRIC HISTORY *PLEASE CONSIDER PARENTS, SIBLINGS, BIOLOGICAL GRANDPARENTS, AUNTS, UNCLES, COUSINS, ETC. FROM BOTH MATERNAL AND PATERNAL SIDE OF THE FAMILY.*
Anxiety	
Depression	
ADHD	
Behavior problems	
Learning difficulties	
Autism Spectrum Disorder	
Obsessions/Compulsions	
Bipolar Disorder	
Schizophrenia	
Problems with alcohol	
Problems with drugs	
Suicide (include attempts)	
Other:	

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	CHILD'S DEVELOPMENTAL HISTORY
Age when first spoke:	
Age when first crawled:	
Age when first walked:	
Age when potty-trained:	
Describe any concerns with your child's development:	

Education

Name of Child's School:_____

Current Grade:_____

Does your child have an IEP? ☐No ☐ Yes 504-plan? ☐No ☐ Yes

If so, what is your child's classification?

☐Multiple Disabilities ☐ Speech or Language Impairment ☐ Autism

☐ Other Health impaired ☐ Learning Disability ☐ Emotional Disturbance

Has your child ever repeated a grade? ☐No ☐ Yes If yes, indicate: _____

Has your child ever been suspended or expelled from school? ☐No ☐ Yes

If yes, please describe: _____

Is attendance a concern for your child? ☐No ☐ Yes

Legal

Does your child 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

If yes, please elaborate:

_____

_____

Has your child ever been out of your custody? ☐No ☐ Yes

If yes, please elaborate:

_____

_____

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Substance Use

Does your child report current use or a history of any of the following?

☐ Illegal drug ☐ Alcohol ☐ Prescription drug ☐ Nonprescription drug ☐ Tobacco

Is there any other information you would like me to be aware of or ask you about?_____

_____

_____

_____

_____

_____

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 (Parent or guardian if minor)

_____

Date

_____

Reviewed by Dr. Davis