Leslie Gavin, Ph.D.
Licensed Psychologist

Intake Questionnaire

Please complete this questionnaire prior to your visit.

Today's Date:

Identifying Information

Patient's Name	**Age**	**Date of Birth**	**Gender**	**Ethnicity**

Address

Family Information:

	Name	Age	Gender	Ethnicity	Job	Bio/half/step?
Parent 1						
Parent 2						
Siblings						
Siblings						
Siblings						

Who are you currently living with?

Name	Age	Relation to you

Best phone numbers:

Name	Cell phone	Landline	email

What is your reason for scheduling an appointment?

Mental Health History

Please provide any mental health diagnoses that you have been given.

Diagnosis	Date of diagnosis	Who diagnosed?

Have you ever taken medications for behavioral/emotional concerns? Yes No? Specify:

Current Medications	Medication for?	Dosage

Have you experienced:

	No	Yes? Please explain
Psychological counseling?		
ABA behavior therapy?		
Occupational Therapy?		
Speech therapy?		
Psychiatric hospitalization?		

Have you experienced:

	No	Yes? Please explain.
Medical Conditions?		
Physical Disabilities?		
Sleep Problems?		
Issues with eating?		
Issues with use of alcohol?		
Issues with use of drugs?		
Concerns about your sexuality?		
Trauma or abuse?		

Education:

	No	Yes	If yes, please explain
Did you receive special services in school (IEP)?	No	Yes	
Did you graduate high school?	No	Yes	
Have you been to college?	No	Yes	
Do you have learning issues?	No	Yes	

Employment History:

Job	How long did you work there?	Why did you leave?

Legal History: Note any legal difficulties including arrests, nature of charges, convictions, pending charges, guardianship, power of attorney.

If possible, please ask your mother the following questions about your childhood:

Were you premature?	Yes	No	
Birth Weight?	lbs	ozs	
Problems during pregnancy?	Yes	No	
Birth trauma?	Yes	No	
Neonatal ICU stay?	Yes	No	
Did you have speech delays?	Yes	No	Therapy?
Did you have delays in walking?	Yes	No	Therapy?
Did you have friends in school?	Yes	No	
Did you have behavior problems as a child?	Yes	No	
Did you have repetitive body movements?	Yes	No	
Did you have sensory sensitivities?	Yes	No	