DAVIS CONSULTANTS, PC

INTAKE QUESTIONNAIRE

To help us expedite the intake process of gathering relevant information about you and your background we ask that you complete this questionnaire prior to meeting with your therapist or evaluator. Please provide as much of the requested information as you can. Doing so will save us a great deal of time during our first meeting.

DEMOGRAPHIC INFORMATION

Date: ______________________

Name: ____________________________

Birthdate: __________________________ Social Security Number: ___________________________

Gender: ❒ Male ❒ Female ❒ Other/Please Ask

*If your Insurance is Workers Compensation, what is your **official Date of Injury**?* _____________________

WHO REFERRED YOU TO OUR CLINIC?

❒ Primary Care Provider: ____

Please provide Name and Phone Number of Primary Care Provider

❒ Other: ____

Please tell us who referred you to our clinic

❒ Self: How did you find out about us? ____

For Example: Yellow Pages, Psychology Today website, Davis Consultants website, etc.

CONTACT PREFERENCES

For the purposes of scheduling, rescheduling, and confirming appointments may we contact you by telephone? ❒ Yes ❒ No

If Yes…

What number should we use for contacting you? _________________________________

May we text you at this number? ❒ Yes ❒ No

May we leave messages identifying the call as coming from our clinic on your voicemail? ❒ Yes ❒ No

Is there anyone other than yourself who might answer your phone? ❒ Yes ❒ No

If Yes...

May we leave messages about your appointments and who we are with that/those individuals? ❒ Yes ❒ No

If Yes...

Please provide the names and your relationship to those individuals below:

Name	***Relationship***

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REASON FOR SEEKING SERVICES

❒ Counseling ❒ Psychological Evaluation ❒ Other

What is the primary issue you are seeking counseling for or evaluation of?

____
____
____
____

For Example: Anxiety, Depression, Substance Use, Pain, etc.

How long have you had this issue?

❒ Less than 1 month ❒ 1-3 months ❒ 3-6 months ❒ 6-12 months ❒ More than 12 months

Have you received services ***for this issue*** from other providers in the past? ❒ Yes ❒ No

If Yes, starting with the most recent please list the names and contact information for those providers in the table below, please include primary care providers and/or other healthcare providers who may have prescribed medication to treat the issue:

Provider/Clinic Name	***City***	***Phone number***

Which of the following treatments have you received for this issue?

❒ Counseling/Psychotherapy ❒ Biofeedback ❒ Medication

❒ Psychiatric Hospitalization ❒ Other: ____
____

If the issue for which you are seeking evaluation or treatment were to be successfully addressed how would your life be different than it is now? ____
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MENTAL HEALTH HISTORY & CURRENT STATUS

*Are you **currently experiencing or have you recently (i.e., last 6 months)** experienced any of the following to a degree that is **distressing** for you, or to a degree that the symptom **causes interference** in your life?*

Difficulty with: ❒Attention ❒Concentration ❒Comprehension ❒Thinking clearly
❒Memory difficulties ❒Problem solving

If yes to any of the above, please explain: ____

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❒ Hallucinations (seeing or hearing things that are not really there or that other people do not see or hear)

If yes, please describe: ____

____

❒ Thoughts or beliefs that other people tell you are crazy

If yes, please describe: ____

____

❒ Mistrust ❒ Suspiciousness ❒ Paranoia

❒ Persistent feelings of sadness/depression last longer than 2 weeks ❒ Suicidal thoughts

❒ Periods of unusually elevated mood lasting at least 3 days

❒ So much energy that you don't need to sleep much for days at a time

❒ Chronic worry that you have difficulty stopping

❒ Anxiety attacks ❒Fear of leaving the house, town, or going places

❒ Upsetting flashback-like memories and/or dreams of past traumatic events

❒ Intrusive unwanted thought or images

If yes, please describe: ____

____

❒ Compulsive rituals (e.g., compulsive hand washing, checking, cleaning, etc.)

If yes, please describe: ____

____

❒ Worry about being evaluated negatively by others when at work, in school, or out in public

❒ Phobias (e.g., fear of heights, water, clowns, etc.): ___________________________________

❒ Problematic eating behaviors ❒ Excessive substance use ❒ Excessive gambling

❒ Difficulty getting along with others ❒ Self-defeating behaviors ❒ Lack of assertiveness

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MENTAL HEALTH HISTORY & CURRENT STATUS *continued*

Please list all previous providers of mental health services in the table below. Please include counselors, psychotherapists, psychologists, psychiatrists, other healthcare providers that may have prescribed psychiatric medications, mental health clinics, psychiatric hospitals, and residential treatment facilities.

Provider/Facility	***Diagnosis/Issue Treated***	***Year***	***City & State***

Have you ever had or do you currently suffer from any of the following conditions?

DISORDER	*PAST*	*PRESENT*	*DETAILS*
Schizophrenia	❒	❒	______________________________
Personality Disorder	❒	❒	______________________________
Depression	❒	❒	______________________________
Bipolar Disorder	❒	❒	______________________________
Posttraumatic Stress Disorder	❒	❒	______________________________
Generalized Anxiety Disorder	❒	❒	______________________________
Obsessive Compulsive Disorder	❒	❒	______________________________
Phobia	❒	❒	______________________________
Eating Disorder	❒	❒	______________________________
Sleep Disorder	❒	❒	______________________________
Other ____________________	❒	❒	______________________________

Do you think that you continue to struggle with any kind of unresolved psychological issues related to your relationships with your parents, other childhood caregivers, or other significant people from your childhood? ❒No ❒Yes

if yes, please explain: ____

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MENTAL HEALTH HISTORY & CURRENT STATUS *continued*

Is there any family history of mental illness? ❒Yes ❒No

If yes, please indicate the nature of the individual's relationship to you and the type of mental illness in the table below:

Relationship	***Type of Mental Illness***

Who or what has the most influence over what will happen in your life?

❒ Yourself ❒ Other people ❒ Chance ❒ Fate ❒ God

What is your preferred method of learning? *(check all that apply)*

❒Demonstration ❒Observation ❒Hands on ❒Reading ❒Verbal Instruction

❒Other: ____________________

TRAUMA HISTORY

Do you have history of exposure to any of the following types of trauma? *(check all that apply)*

❒Physical abuse/assault ❒prior to age 18 ❒after age 18

❒Emotional abuse ❒prior to age 18 ❒after age 18

❒Sexual abuse/assault ❒prior to age 18 ❒after age 18

❒Serious motor vehicle accident(s)

❒Natural disaster(s)

❒Military combat

❒Kidnapping

❒Torture

❒Occupational Injury

❒Hostile work environment

❒Other (Please explain): ____

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PHYSICAL HEALTH HISTORY & CURRENT STATUS

What is your current height? ___________________

What is your current weight? ___________________

Do you wear or need glasses or contacts? ❒Yes ❒No

Do you use or need hearing aids? ❒Yes ❒No

Do you have any problems with your senses of: ❒Touch ❒Smell ❒Taste ❒No

*Are you **currently frequently** experiencing any of the following?*

❒ Difficulty breathing ❒ Chest pain ❒ Stopping breathing during sleep ❒ Shortness of breath

❒ Abdominal pain ❒ Decreased range of motion ❒ Joint pain ❒ Muscle aches/pains

❒ Dizziness/vertigo ❒ Headaches ❒ Seizures ❒ Fatigue

❒ Significant unintended weight gain ❒ Significant unintended weight loss

❒ Change in sleep pattern

❒ Other: ____

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Who is your Primary Care Provider? ____

Please list any other healthcare providers you are currently working with on an ongoing basis

Provider Name	***Condition Treated***	***Date of Most Recent Encounter***

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HEALTH HISTORY & CURRENT STATUS Continued

Please list any chronic health conditions you are currently living with:

Condition	***Treating Healthcare Provider***	***Treatment***

Have you ever had or do you currently suffer from any of the following conditions?

DISORDER	*PAST*	*PRESENT*	*DETAILS*
Chronic Pain	❒	❒	________________
Cancer	❒	❒	________________
Thyroid Trouble	❒	❒	________________
Cardiovascular/Heart Disease	❒	❒	________________
Asthma or other Respiratory Disease	❒	❒	________________
Diabetes	❒	❒	________________
Head Injury	❒	❒	________________
Loss of Consciousness	❒	❒	________________
Seizure Disorder	❒	❒	________________
Schizophrenia	❒	❒	________________
Personality Disorder	❒	❒	________________
Depression	❒	❒	________________
Bipolar Disorder	❒	❒	________________
Posttraumatic Stress Disorder	❒	❒	________________
Generalized Anxiety Disorder	❒	❒	________________
Obsessive Compulsive Disorder	❒	❒	________________
Phobia	❒	❒	________________
Eating Disorder	❒	❒	________________
Sleep Disorder	❒	❒	________________
Other ________________	❒	❒	________________

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HEALTH HISTORY & CURRENT STATUS Continued

Please list all surgical procedures you have had below:

Procedure	***Date***

Please list all your current medications and supplements below:

Medication/Supplement	***Dose***	***For What Condition***

SUBSTANCE USE HISTORY AND CURRENT STATUS

Do you use tobacco products? ❒Yes ❒No

If yes, ❒ Smoke ❒ Chew

If you used tobacco in the past, when did you quit? ______________________

Do you now or have you ever consumed alcoholic beverages? ❒Yes ❒No

If Yes, how many alcoholic beverages do you currently consume in a typical week? ___________

Do you have a history of alcohol abuse? ❒Yes ❒No

Do you now or have you ever used illegal drugs? ❒Yes ❒No

If Yes, which drugs, when, and how frequently: ____

____

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SUBSTANCE USE HISTORY AND CURRENT STATUS Continued

Do you now or have you ever misused prescription drugs? ❒Yes ❒No

If Yes, which drugs and when: ____

____

Do any of your immediate family members have a history of:

❒ Alcohol abuse, if Yes, who: ____

❒ Illegal drug abuse, if Yes, who: ____

❒ Prescription drug abuse/misuse, if Yes, who: ______________________________________

Do you gamble? ❒ Yes ❒ No ❒ Uncertain

If Yes, do you gamble excessively? ❒ Yes ❒ No ❒ Uncertain

How many caffeinated beverages do you consume most days? ________________________________

Please list all past episodes of substance use disorder treatment below:

Name of Provider or Clinic	***Dates***	***For What Condition(s)***

RESIDENTIAL & DEVELOPMENTAL HISTORY

Please list the different places you have lived during your life and the years you lived in each:

City & State or Country	***Dates***

Did your mother drink or use drugs while she was pregnant with you? ❒ Yes ❒ No

Were there any problems with your pregnancy or birth? ❒ Yes ❒ No

Did you have any serious health problems as an infant or very young child? ❒ Yes ❒ No

Did you have any developmental problems or delays? ❒ Yes ❒ No

If Yes to any of the previous 3 questions, please explain: ________________________________

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EDUCATIONAL HISTORY

What is your highest level of education?

❐ Did not graduate from high school
❐ GED
❐ High school graduate
❐ Technical school certificate
❐ Some college
❐ College graduate
❐ Graduate degree

Have you ever been diagnosed with a Learning Disability? ❐ Yes ❐ No

If Yes, what type of Learning Disability? ____

OCCUPATIONAL STATUS/HISTORY

Are you currently:

❐ Working full-time ❐ Working part-time ❐ Unemployed ❐ Retired
❐ Receiving temporary disability benefits ❐ Receiving permanent disability benefits

If currently working or on temporary disability, what is your occupation? ___________________
____

How much do you/did you like your job?

Love[d] my job										*Hate[d] my job*
0	1	2	3	4	5	6	7	8	9	10

If you do not/did not like your job, please explain why ___________________________________
____

Prior to your current or most recent occupation what other kinds of jobs have you had during your lifetime? ____
____
____

How many hours per week do you spend in work and/or school-related activities? __________________

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LEGAL STATUS/HISTORY

Are you currently involved in any lawsuits? ❒ Yes ❒ No

If Yes, please briefly describe the nature of the litigation and provide your attorney's name and phone number: ____
____

Do you have a lawyer helping you with obtaining Workers Compensation benefits? ❒ Yes ❒ No

If Yes, please provide your attorney's name and phone number: ________________________
____

Are you currently applying for Social Security disability benefits? ❒ Yes ❒ No

If Yes, and if you have an attorney assisting you, please provide your attorney's name and phone number: ____

Have you ever been convicted of a criminal offense? ❒ Yes ❒ No

If Yes, what criminal offense(s) have you been convicted of? ___________________________
____

If Yes, are you currently under any type of legal supervision? ❒ Yes ❒ No

If Yes, nature of supervision: ____

FINANCIAL HISTORY/STATUS

Would you describe your current financial status as: ❒Stable ❒Unstable

Have you ever declared bankruptcy? ❒Yes ❒No

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RELATIONSHIP HISTORY/STATUS

What is your current relationship status?

❒ Single/Never Married ❒ Married ❒ Unmarried but living with partner ❒ Separated
❒ Divorced

Number of Marriages/Live-in Partners: ______________________

If not currently living with a partner, are you involved in an intimate relationship? ❒ Yes ❒ No

Do you have any history of involvement in domestic violence? ❒ Yes ❒ No

If yes: ❒ Current ❒ Past

Number of children: __________ Number of children living in your home: _______________________

Is there anyone else living in your home? ❒ Yes ❒ No *If Yes, who?* _____________________________

SOCIAL/INTERPERSONAL STATUS

Do you own your home? ❒ Yes ❒ No
Do you rent? ❒ Yes ❒ No
Do you have a valid driver's license? ❒ Yes ❒ No
Do you have a vehicle that you drive? ❒ Yes ❒ No

In general, do you have difficulty making and keeping friends? ❒ Yes ❒ No
Would you normally describe yourself as a loner? ❒ Yes ❒ No
In general, do you trust other people? ❒ Yes ❒ No
Do you normally lose your temper easily? ❒ Yes ❒ No
Are you normally an impulsive sort of person? ❒ Yes ❒ No
Are you normally a worrier? ❒ Yes ❒ No
In general, do you depend on others a lot? ❒ Yes ❒ No
In general, are you a perfectionist? ❒ Yes ❒ No

Do you participate in any social, community, spiritual, club, or other types of regularly scheduled activities? ❒ Yes ❒ No

If Yes, what activities? ____
____

Please rate your level of engagement in social/recreational/community activities?

No Activities *Many Activities*

0 1 2 3 4 5 6 7 8 9 10

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CURRENT STRESSORS

What are the primary sources of stress in your life at the present time? ____________________________
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DAILY ROUTINE

What time do you usually get out of bed to start your day? ______________________________________
What time do you usually go to bed at the end of your day? ______________________________________
What do you do with your time when you are not working or going to school: ______________________
____
What are your hobbies or pastimes? ____
____

HEALTH HABITS

Do you exercise? ❒Yes ❒No

If Yes, what kind of exercise do you do and how frequently? ________________________________
____

Do you meditate or engage in any type of formal relaxation practice? ❒Yes ❒No

If Yes, what kind of exercise do you do and how frequently? ________________________________
____

Do you regularly use any stress management strategies? ❒Yes ❒No

If Yes, what kind of exercise do you do and how frequently? ________________________________
____

SPIRITUAL/RELIGIOUS STATUS

Please indicate your spiritual/religious status:

❒ Atheist ❒ Agnostic ❒ Buddhism ❒ Christian ❒ Islam ❒ Judaism
❒ Traditional Native American ❒ Other: ____

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AVERSIVE CHILDHOOD EXPERIENCE QUESTIONNAIRE

Because a history of aversive childhood experience has been shown to have a strong impact on physical health and emotional well-being later in life we would like to find out to whether you experienced aversive events during your childhood, and if so, to what degree. We understand that the following set of questions are very personal, however, it is very important for us to have this information if we are going be able to work with you effectively. If you would prefer to answer these questions in person during your initial interview, we will be happy to accommodate you.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often …**

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt? ❒ Yes ❒ No

---

2. Did a parent or other adult in the household **often or very often …**

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured? ❒ Yes ❒ No

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3. Did an adult or person at least 5 years older than you **ever**…

Touch or fondle you or have you touch their body in a sexual way?

or

Attempt or actually have oral, anal, or vaginal sex with you? ❒ Yes ❒ No

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4. Did you **often or very often** feel that …

No one in your family loved you or thought you were important or special?

or ❒ Yes ❒ No

Your family didn't look out for each other, feel close to each other, or support each other?

---

5. Did you **often or very often** feel that …

You didn't have enough to eat, had to wear dirty clothes,
and had no one to protect you?

or ❒ Yes ❒ No

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

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AVERSIVE CHILDHOOD EXPERIENCE QUESTIONNAIRE continued

6. Were your parents **ever** separated or divorced? ❒ Yes ❒ No

7. Was your mother or stepmother:

Often or very often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit at least a few minutes or threatened with a gun or knife? ❒ Yes ❒ No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? ❒ Yes ❒ No

9. Was a household member depressed or mentally ill or did a household member attempt suicide? ❒ Yes ❒ No

10. Did a household member go to prison? ❒ Yes ❒ No

Is there anything else you think we should know or that you want to be sure we know about you or your situation?

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